

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series

17

Gerald L. Vigdal, M.S.W., B.C.D.

Consensus Panel Chair

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Substance Abuse and Mental Health Services Administration

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Table of Contents

- [\[Title Page and Front Matter\]](#)
- [Chapter 1 -- Introduction](#)
- [Chapter 2 -- The Effectiveness of AOD Treatment in the Criminal ...](#)
- [Chapter 3 -- The AOD-Involved Offender](#)
- [Chapter 4 -- The Criminal Justice Continuum](#)
- [Chapter 5 -- The AOD Abuse Treatment System](#)
- [Chapter 6 -- Collaboration Between Systems](#)
- [Chapter 7 -- Coordinated Training](#)
- [Chapter 8 -- Confidentiality Issues](#)
- [Chapter 9 -- Evaluation](#)
- [Appendix A -- Bibliography](#)
- [Appendix B -- CSAT Criminal Justice Treatment Planning Chart](#)
- [Appendix C -- Sample Interagency Agreement](#)
- [Appendix D -- Federal Resource Panel](#)
- [Appendix E -- Field Reviewers](#)
- [Exhibits](#)
- [Exhibit 4-1 Forms of Intermediate Sanctions](#)

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[\[Front Matter\]](#)

[\[Title Page\]](#)

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The opinions expressed herein are the views of the consensus panel members and do not reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized patient care and treatment decisions.

What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then transmitted to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Chair for the panel is charged with responsibility of ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the Chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment in public and private programs recognized for their provision of high quality and innovative AOD abuse treatment.

This TIP *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* presents guidelines to help bring the criminal justice and AOD systems closer together, to more systematically promote the acceptance of AOD treatment for criminal offenders, and to enhance the effectiveness of that treatment. The current state of AOD treatment in the criminal justice system is reviewed, and selected characteristics of AOD-involved offenders are described. An overview of the criminal justice continuum, from arrest and pretrial through jail and prison, is presented. Goals and components of AOD abuse treatment are described, and a systems approach to planning and implementing AOD treatment in the criminal justice system is outlined. Issues such as training staff, protecting client confidentiality, and evaluating processes and outcomes are addressed in individual chapters.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

Other TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol Series (TIPs) fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

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Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Chapter 1 -- Introduction

A great deal has been written about the relationship between alcohol and other drug (AOD) abuse and crime in the last decade. Research has shown that criminal offenders have much higher levels of drug use than non offenders ([National Institute of Justice, 1992](#)). Surveys of offenders in both jails and prisons also indicate that these individuals had higher rates of drug use before becoming involved with the criminal justice system ([Bureau of Justice Statistics, 1993a](#)). The correlation between substance use and criminal behavior is underscored by several studies that have linked increased substance use with greater likelihood of committing an offense ([Ball et al., 1987](#); [Nurco et al., 1985](#); [Shaffer et al., 1987](#)).

Recent efforts to decrease the number of drug-related crimes have focused on drug interdiction, arrest, mandatory sentencing, prosecution, and incarceration. These efforts have had minimal impact on drug use and the violence associated with distribution and sale of illegal substances. Billions of dollars have been invested in these efforts, but the criminal justice system is still overburdened with an enormous number of offenders. In some jurisdictions, the criminal justice system has almost ground to a halt because of the number of drug-related offenders.

One result of these failures is frustration. Across the country, neighborhoods and communities are expressing increasing frustration with violence. Police are frustrated by the conditions they face. Courts have become overburdened, and in some jurisdictions, the judiciary refuses to hear drug cases, and judges call for the legalization of drugs. In other jurisdictions, the credibility of probation agencies has diminished because officers must supervise increasing numbers of offenders. In addition, despite expensive building programs, jails and prisons are crowded, and officials are often required to release offenders who have served only small portions of their sentences. In some areas, prison building programs were undertaken without proper planning, sometimes for political reasons, and new facilities stand unopened because funds for prison staff were not allocated. This accumulated frustration has led some people to believe that the problems associated with AOD abuse and crime have no workable solutions.

Although there is increasing frustration with efforts to curb drug-related crimes, evidence has been consistent in demonstrating that alcohol and drug abuse treatment not only reduces AOD use, but also reduces criminal activity.

However, strong empirical evidence has been accumulating, especially during the past 2 decades, that alcohol and drug abuse treatment not only reduces AOD use, but also reduces criminal activity ([Anglin and Hser, 1990](#); [Aspler and Harding, 1991](#); [Harwood et al., 1988](#); [Hubbard et al., 1989](#); [Gerstein and Harwood, 1990](#); [McGlothlin and Anglin, 1981](#); [McLellan et al., 1983](#)). A recent 2-year study -- the California Drug and Alcohol Assessment, the largest followup study of its kind ever conducted -- showed that each dollar spent for AOD treatment saved \$7.14 in future costs, largely in relation to costs avoided because of reductions in crime ([California Department of Alcohol and Drug Programs, 1994](#)).

Among the 150,000 participants being studied, the level of crime declined by two-thirds in the year after treatment. This reduced rate of criminal activity continued into the second year posttreatment for a smaller sample followed for 2 years. Another important finding of the California study was that the longer individuals stayed in treatment, the greater was the percentage of reduction in criminal activity among them.

Because of the increasing evidence of the effectiveness of AOD treatment in reducing crime, and the frustrations of so many groups inside and outside the criminal justice system, a major purpose of this Treatment Improvement Protocol (TIP) is to aid the growing efforts to forge and strengthen links between the criminal justice and AOD treatment systems. The goals of these efforts are to more systematically promote the acceptance and enhance the effectiveness of AOD treatment for criminal offenders.

Like many complex systems, the criminal justice system can sometimes seem to be a cluster of agencies acting independently, each with its own set of goals and objectives and each sometimes working at cross-purposes with the others. The alcohol and drug abuse treatment system is also a complex network of many agencies and disciplines, striving to build on its strengths to create a cohesive system. There is a major challenge in bringing these two complex systems closer together. However, a significant reduction in AOD abuse and crime will not occur until the two systems effectively coordinate their efforts.

The Purpose of This Tip

The purpose of this TIP is to offer guidelines to administrators, planners, policymakers, and frontline personnel in both the criminal justice and AOD abuse treatment systems for opening and continuing a dialogue on treatment for offenders. The thrust is to build effective linkages between these systems. Thus, the goals of this TIP are to develop increased mutual understanding and respect between personnel in the two systems and to encourage them to jointly define purposes and objectives.

In 1994, the largest study of its kind ever conducted showed that each dollar spent on alcohol and other drug abuse treatment resulted in \$7.14 savings to the criminal justice system.

Principles Guiding the Panel

No single answer will be found to the complex problems related to AOD abuse among criminal offenders. Rather, steps can be taken to promote the goals of reducing the prevalence of AOD abuse in this population and thereby decreasing crime, violence, and the spread of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and other sexually transmitted diseases and tuberculosis (TB). The panel that developed this TIP brought to the table expert knowledge of offenders and criminality, the current problems faced by the criminal justice system, and AOD abuse and effective treatment. The panel agreed on several key points that formed a framework for developing recommendations:

- **Drug users are not a homogeneous group.** Drug users range from citizens who experiment with drugs and experience few or no adverse consequences, to those whose use of drugs brings severe and adverse consequences.
- **Treatment works.** As discussed above, the last 20 years of research have repeatedly shown that treatment can reduce drug use and crime.
- **A single treatment program or approach will not be successful for all offenders.** Although advocates of different treatment models promote specific regimens, treatment success depends on matching treatment to offender needs. For example, some offenders who have not demonstrated serious antisocial behavior and who have adequate social supports can be treated successfully in the community. However, many severely antisocial offenders require long-term residential treatment combined with additional services. Other offenders may benefit from outpatient opioid substitution therapy (methadone or levo-acetyl-methadol [LAAM]), with varying degrees of counseling and adjunct services.
- **Incarceration alone usually does little to change behavior.** Although the fear of arrest or incarceration may deter some offenders from drug use, there is little evidence that incarceration without treatment does anything to effect behavioral change. Incarceration may not even interrupt the offender's drug use, since it is well known that illegal drugs are available in some jails and prisons.
- **People without a stake in society may view antisocial behavior as a way to maintain a sense of power.** Citizens who have a stake in society generally guard against losing their position, status, and possessions. Those who feel disenfranchised -- who believe they have no status, power, or possessions and no legitimate way to acquire them -- may behave antisocially. Offenders frequently do not share the values of mainstream America, and efforts to change behaviors in this population must address issues of disenfranchisement.
- **Long-term reduction of drug use is dependent on changes in society's attitudes about the justice system's role in prevention.** The majority of criminal justice resources now are dedicated to drug interdiction, arrest, prosecution, and sanctions -- that is, the problems are addressed after they occur. Recently, in many areas of American society, individuals and groups have joined the struggle to prevent AOD abuse. The criminal justice system has increasingly recognized the power of prevention measures at the community level, and it is vital that leaders inside and outside of the system communicate to the public the appropriateness of the criminal justice system's participation in prevention efforts.
- **Long-term reduction in drug use is dependent on changes in society's ambivalent attitudes about drug use.** Prevention and treatment efforts are hampered by ambivalence at all levels of society about drug use. Until the unacceptability of drug use becomes widespread, we will

continue to cycle people through the criminal justice system in ever-increasing numbers and at increasing cost.

The delivery of AOD abuse treatment to a criminal justice population can best be grounded in the following principles, which also guided the panel's efforts:

- Treatment is not a substitute for punishment or sanctions.
- Treatment should be universally available as needed for persons who come to the attention of the criminal justice system.
- AOD treatment services should be tailored to the needs of the specific offender, based on a thorough assessment that should occur as early as possible after the offender enters the criminal justice system.
- Offender supervision should not be relinquished once an individual enters treatment.
- Offenders should remain accountable to the sentencing judge or the probation or parole authority.

Issues and Challenges

The Scope of the Problem

More than one million people are in jails and prisons, and 3.5 million are on probation and parole in our communities. The number of drug-abusing offenders in the justice system has increased dramatically. In 1991, drug offenders accounted for 56 percent of the population of Federal correctional facilities, up from 25 percent in 1979. Arrests related to AOD use increased by 126 percent during the last decade. The National Justice Institute estimates that up to 80 percent of offenders, parolees, and probationers have some degree of substance abuse problem related to their criminal activity.

Many offenders cycle in and out of the justice system; these repeat offenders account for a significant proportion of crime. Given these facts, it is logical to assume that intervening with the offender population to prevent and treat AOD use and abuse will have a major impact on reducing crime. However, components of the criminal justice system often work at cross-purposes, and it has been the exception rather than the rule when the criminal justice and AOD systems work well together.

System Differences

A basic difference between the criminal justice and AOD systems is that the primary responsibility of the former is to protect public safety. This serious responsibility entails a focus on laws, procedures, and processes that are largely designed to incapacitate and punish individuals who threaten the lives and well-being of others. The AOD abuse treatment system has a serious responsibility to address the great harm that AOD abuse and dependence exact on individuals, their families and friends, and the organizations and communities in which they interact. This responsibility often entails a focus on providing support and understanding to facilitate individual change.

It is the basic differences in these systems that have created obstacles to understanding and cooperation. Personnel in each system often have incomplete views of each other. Traditionally, treatment system personnel see those in the criminal justice system as narrowly focused on punishment, and criminal justice personnel see treatment providers as "do-gooders" who know nothing about holding people accountable for their behavior. Although evidence can be found in both systems to support these biases, each system has more depth than the stereotypes suggest. Even though the two systems work from different incentives, values, training, and standards, they share common goals for the benefit of society: the reduction of deviant behavior and the reduction of AOD use and associated criminal activity.

It is also important to recognize that neither system is homogeneous. There are different "cultures" within each system. In the AOD abuse treatment system, for example, methadone maintenance program staff and therapeutic community staff may have different points of view. Similarly, within the criminal justice system, probation officers often have different perspectives from public defenders.

Lack of Knowledge

Not only do criminal justice personnel often have little understanding of what treatment can do and how the AOD treatment system provides services, justice system personnel (and the general public) often have little understanding of different treatment models and philosophies. Some criminal justice personnel believe that treatment providers often choose to treat offenders who have minimal behavior problems and respond well to treatment. After repeated contact with offenders who appear to be "failures," criminal justice staff conclude that AOD treatment is ineffective. On the other hand, treatment providers may believe that the criminal justice system refers offenders who are unsuitable for treatment, creating situations conducive to treatment failure.

Even though criminal justice and AOD treatment systems work from different incentives, values, training, and standards, they share common goals: the reduction of deviant behavior for the benefit of society and the reduction of AOD use and associated criminal activity.

Situations that result in "failure" are often created by a lack of knowledge. For example, criminal justice staff may refer an offender to the wrong treatment provider because they don't know which provider is appropriate and so place the offender in any available treatment slot. On the other hand, treatment providers may not clearly understand a criminal justice procedure, such as chain of custody for urine samples. In addition, justice system personnel may not realize that, like any treatment for a serious, chronic condition, AOD treatment takes time, and the amount of time allowed for treatment for many offenders is brief because of limits on sentences and sanctions. Although criminal justice system staff may want treatment for "hard-core" users, treatment providers generally prefer to use slots for offenders who are at an earlier stage of their addiction and who have greater likelihood of success within a limited treatment period. Providers' funding may depend in part on demonstrating that they are providing effective treatment.

Who Should Be Served?

Questions arise about which AOD-involved offenders are being served and who *should* be served. Who decides? Do the decisionmakers have the knowledge and qualifications required for performing this task? Where should clients be served? If it were left to each system to give subjective responses to these questions, two very different positions might emerge. Treatment providers, who work with limited resources, usually want clients who have the best chances of success. As a result, they may deny the serious drug dependencies of some AOD-involved offenders who are referred to their programs, or they may deny services to some offenders.

The offender's views and situations often create additional problems, especially those related to noncompliance. Many offenders prefer "doing time" to entering treatment, framing the choice as a "manhood" or power issue. Often, the nonincarcerated offender's home environment cannot support a drug-free life-style because the offender has no job around which to structure his or her day.

Fortunately, personnel throughout both systems are beginning to realize that court sanctions can be an important part of the treatment process. "Leveraging" offenders into treatment under criminal justice sanctions often adds the accountability that the criminal justice system requires, while providing the treatment system with clients more willing to comply with the demands of treatment. (Another TIP in this series, TIP 12: *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, addresses issues surrounding noncompliance and the leverage that sanctions provide.)

New Approaches

Despite the persisting negative stereotypes and misunderstandings described in this chapter, a growing number of individuals in both systems agree that new approaches must be tried. Criminal justice workers see the futility of arresting the same offenders repeatedly, and treatment providers recognize the need for controlling and prosecuting offenders who threaten the security of the community. Once representatives from both systems discuss these issues, they usually reach conclusions that transcend their negative stereotypes. For example, criminal justice personnel begin to view relapse as an expected part of recovery, and treatment staff learn that the added accountability of the justice system can assist in keeping their clients in treatment.

A Change in Thinking: Public Education

The goals of the AOD treatment and criminal justice systems are closely related. Both systems seek to reduce AOD abuse. The ultimate goal of both systems is to ensure that individuals can interact in positive and constructive ways to improve personal and community welfare; they just approach this goal in different ways. A specific goal of the criminal justice system is to protect the community. Positive treatment outcomes support this goal by helping to reduce criminal recidivism.

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justice workers see the futility of arresting the same offenders repeatedly, and treatment providers recognize the need for controlling and prosecuting offenders who threaten the security of the community. Once representatives from both systems discuss these issues, they usually reach conclusions that transcend their negative stereotypes.

Even though both systems share goals, accepting the recommendations of this TIP -- linking the two systems -- may require program planners, managers, legislators, and the public to change some of their basic views. The discussions included here about the relationships among treatment, crime, the criminal justice system, and community protection may include ideas that some people will find difficult to accept.

A major public education effort will be required to bring about a change in thinking. To reallocate some financial resources used for building prisons and other correctional facilities and use the money to establish treatment for persons in the criminal justice system instead will require significant financial reordering. For such a reallocation of resources to become a reality, people must believe that establishing treatment in the criminal justice system is in their own best interests.

In addition to educating the public about needed changes, it is vital that the public know what methods are already working. For example, each area of the criminal justice system can prepare and release annual reports similar to corporate annual reports developed for the community and showing the number of individuals who need treatment and the number who have successfully completed programs. The media also can play a major role in influencing public opinion about AOD abuse and the effectiveness of treatment. While negative publicity can hurt both the criminal justice and treatment systems, the media can be very helpful if approached in an open way and provided with facts from the justice system and AOD treatment perspectives. Communication with the media is an area where shared views between systems are all important.

Developing a Shared Strategy

System representatives can begin developing shared strategies by identifying the best opportunities for treatment. Each stage of the criminal justice continuum can link with different stages of the treatment continuum. For example, AOD education or assessment and urine testing could be a condition for release on bail or at arraignment. Treatment and urine monitoring could begin while the offender is awaiting trial and, if appropriate, continue as part of sentencing. Relapse prevention and aftercare can be part of probation or parole.

The continuum of AOD treatment modalities is similar to the criminal justice punishment continuum in several ways. The criminal justice continuum has the least restrictive sanctions at one end and the most restrictive sanctions at the other. In a like manner, the treatment continuum moves from the least to the most intensive treatment interventions. If an offender fails at one point on the treatment continuum, this setback does not indicate total failure. Other programs and other approaches can be tried. Supervised offenders at any point of the continuum also can be placed in the appropriate stage of treatment. For example, in most jurisdictions, a large majority

of cases are plea-bargained. This bargaining stage provides an excellent opportunity to bring the AOD treatment system into the justice system. The more information prosecutors have about the long-term impact of treatment, the more informed their decisions can be in the plea-bargaining process.

However, it should be noted that the nature of the crime can dictate the treatment setting. For example, serious offenders who have been sentenced to incarceration would have to be assigned to a residential or inpatient treatment setting even if their drug addiction were mild. On the other hand, an offender who has committed a relatively minor felony may have a serious addiction requiring residential treatment. Judges are often obligated to mandate the least restrictive criminal justice setting based on the nature of the crime, regardless of the severity of addiction, although some judges interpret this obligation differently.

A broader way of conceptualizing the AOD treatment continuum is placing public awareness and prevention at one end; intervention, outreach, treatment, and ancillary services in the middle; and relapse prevention and aftercare at the other end. This arrangement would coincide with the criminal justice continuum of arrest, bail, arraignment, trial, sentencing, probation, incarceration, and parole.

Drug Courts and Diversion

It should be noted here that extensive cooperative efforts have already been undertaken in the form of drug courts and other efforts to divert some substance-abusing offenders into treatment rather than into extensive, costly, and often repeated involvement with the justice system. The national crime bill passed in late 1994 allocated \$1.8 billion to drug courts. Drug courts are special courtrooms that integrate substance abuse treatment and justice system case processing under close supervision of a judge. This approach has evolved and attained significant success over a period of 20 years. There are dozens of well-established programs, including those in Oakland, California; Fort Lauderdale, Florida; Portland, Oregon; Phoenix, Arizona; and Washington, D.C. New programs are in development across the country.

No two programs are exactly alike, but these treatment-oriented drug court programs have some common threads. All of them build on an underlying premise that drug use, possession, and sale do not represent simply a law enforcement problem -- these activities are just as much a public health problem as a criminal justice problem. Accordingly, drug court proponents generally recognize that the traditional punitive model of drug enforcement and prosecution has failed to have much impact on the drug problem and has overwhelmed the criminal justice system with cases. Proponents of the drug court model argue that solutions to the drug crisis are more likely to lie in using AOD treatment to effect long-term solutions.

All of these programs involve a conception of the role of the court (and of judges and lawyers) that goes well beyond the traditional narrow view of the court as simply an adjudicative institution. This approach places at least as much emphasis on effective treatment of individuals with substance abuse problems as on the adjudication of cases. Drug courts involve the close collaboration of courts with the AOD treatment community and with other societal institutions in

the design and ongoing operation of the program. These programs share the understanding that substance abuse is a chronic, progressive, relapsing disorder that can be treated successfully.

The conviction that treatment works -- not in every case, but often enough to make implementation of treatment-oriented drug courts a better alternative than conventional case processing for some types of cases -- is a key premise of the programs. Successful operation of these programs involves the cooperation and collaboration of many institutions and individuals. It is beyond the scope of this TIP to describe in detail the concepts and operations of drug courts and diversion processes. However, other TIPs in this series (e.g., TIP 23: *Treatment Drug Courts: Integrating Substance Abuse Treatment with Legal Case Processing* and TIP 21: *Combining Substance Abuse Treatment With Diversion for Juveniles in the Criminal Justice System*) examine the cooperation of the two systems in these areas.

Organization of This Volume

This TIP explores the interrelated functions of the criminal justice and treatment systems from arrest through arraignment, pretrial hearings, conviction, sentencing, probation, incarceration, and parole. It has been developed by a panel of experts from the criminal justice and substance abuse treatment fields, working together and sharing their ideas on systems coordination. This TIP addresses not only the vertical relationships between the criminal justice system and AOD treatment from one stage in the criminal justice system to the next, but also the horizontal relationships and cooperative opportunities within each stage of the criminal justice system.

The panel hopes that this TIP will help readers develop a broader understanding of each of these systems so that they will be better prepared to join the efforts to strengthen linkages between them. The development of this TIP provided panel members from both systems with the opportunity to cooperate to provide leadership and guidance for establishing coordinated systems. Although this TIP includes descriptions of coordinated criminal justice and AOD services that do not exist in many communities, panel members are encouraged by the success of their own cooperative efforts and believe that such linkages are worthy and attainable goals.

This TIP has a wide audience, spanning both the criminal justice and AOD treatment systems. Since the TIP strives to educate persons from each system about the other, some discussions and entire chapters may review concepts that are new to one group and highly familiar to another. However, in each discussion, the panel has attempted to link ideas and reframe concepts so that readers from both systems will benefit.

Drug court proponents generally recognize that the traditional punitive model of drug enforcement and prosecution has failed to have much impact on the drug problem and has overwhelmed the criminal justice system with cases. Proponents of the drug court model argue that solutions to the drug crisis are more likely to lie in using AOD treatment to effect long-term solutions.

[Chapter 2](#) The Effectiveness of AOD Treatment in the Criminal Justice System reviews studies of the effectiveness of treating offenders and discusses issues related to funding.

[Chapter 3](#) The AOD-Involved Offender describes characteristics of persons involved with the criminal justice system who are also substance abusers. Cultural, ethnic, and gender issues are discussed. Other important factors related to AOD abuse in this population, such as the spread of HIV/AIDS and TB, are addressed.

[Chapter 4](#) The Criminal Justice Continuum provides an overview of the criminal justice continuum from arrest and pretrial through incarceration and release. It is largely aimed at persons in the treatment system who are unfamiliar with judicial processes.

The first part of [Chapter 5](#) The AOD Abuse Treatment System introduces the AOD treatment system to those in the justice system who may lack knowledge of basic treatment concepts. The chapter also includes a discussion of implementing treatment in the criminal justice system. Information is presented to help treatment providers in the justice system understand the importance of State funding using Federal treatment dollars. Treatment approaches and treatment types are described, and case-managed approaches are discussed. Finally, the use of incentives and sanctions is reviewed, as is the importance of planning for the provision of treatment within the criminal justice system.

[Chapter 6](#) Collaboration Between Systems is an overview discussing the use of stakeholders in a systems planning approach that coordinates treatment and other services for AOD abusers involved in the criminal justice system. Strategies to implement change are described, including strategies for the formation of a planning group.

[Chapter 7](#) Coordinated Training stresses the importance of training and, most important, coordinated training. Specific topics for training sessions and resources for obtaining training materials are described.

[Chapter 8](#) Confidentiality Issues reviews the legal issues surrounding the confidentiality of AOD-related information that is protected by Federal regulations. Issues include procurement of the offender's consent, communication between systems, and exceptions to confidentiality rules.

[Chapter 9](#) Evaluation outlines issues related to program and system evaluations.

[Appendix A](#) is a list of the references cited in the TIP. [Appendix B](#) is the Center for Substance Abuse Treatment (CSAT) Criminal Justice Treatment Planning Chart. This chart provides an overview of the criminal justice continuum, showing the flow of cases through the system. Accompanying the chart is a glossary of common terms and concepts used in both the criminal justice and AOD treatment systems. [Appendix C](#) provides a sample of an interagency agreement that sets forth the responsibilities of both the AOD treatment system and the criminal justice system to ensure that drug-involved offenders receive appropriate treatment and supervision. [Appendix D](#) lists the names of persons who attended the Federal resource panel in the early stages of development of the TIP. [Appendix E](#) lists the names of experts from across the country who participated in a field review of the TIP.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Chapter 2 -- The Effectiveness of AOD Treatment in the Criminal Justice System

In 1991, it was estimated that of the 680,000 inmates in State prisons nationwide more than 500,000 had substance abuse problems. However, States had the resources to provide treatment to less than 20 percent of prisoners ([General Accounting Office, 1991](#)). In the same year, only 364 inmates of Federal prisons were receiving treatment in intensive residential programs, and aftercare services were not in place ([General Accounting Office, 1991](#)).

This chapter provides an overview of several studies that focus on AOD treatment within the criminal justice system and reviews the evidence related to treatment effectiveness.

Coerced Treatment

A major issue in serving offenders is the effectiveness of treatment for drug abusers who are coerced into treatment. Several authors ([Hartjen et al., 1982](#); [Platt et al., 1988](#); [Rosenthal, 1988](#)) have argued that there is little benefit when a client is forced into treatment by the criminal justice system. Some researchers are opposed to coerced treatment on philosophical or constitutional grounds, while others argue against coerced treatment on clinical grounds, maintaining that treatment can be effective only if the person wants to change. Other authors ([Anglin and Maugh, 1992](#); [Orsagh and Marsden, 1985](#); [Salmon and Salmon, 1983](#)) have argued that few chronic addicts will enter treatment without some type of external motivation and that legal coercion is as justified as any other treatment motivation.

Advocates of coerced treatment also cite empirical evidence that coercion does not impair treatment effectiveness. For example, [Sells and Simpson \(1976\)](#) and [Simpson and Friend \(1988\)](#) examined the effect of contact with the criminal justice system at treatment admission on the length of stay in treatment and on the performance of clients during and after treatment. They found that those entering treatment with some legal involvement functioned as well as those who

entered voluntarily. A number of other studies also report that legal pressure increases admission rates into treatment programs and promotes treatment retention.

[Anglin and associates \(1989\)](#) compared three groups of heroin addicts who entered methadone maintenance treatment under high, moderate, or low coercion. They found no significant differences among the groups at followup on measures of drug use and criminal behavior, indicating that those coerced into treatment benefited as much as those entering voluntarily. [De Leon \(1988\)](#) reported that clients who were legally referred to therapeutic communities stayed in treatment longer than those admitted voluntarily, and that posttreatment outcomes were similar. These studies support the argument that users can benefit from treatment even if their motivation for entering treatment is external.

More recently, [Goldkamp and Weiland\(1993\)](#) evaluated the effectiveness of the Dade County felony drug court, known as the "Miami model." Since 1989, when Dade County implemented the drug court model, defendants have been referred primarily to the Diversion and Treatment Program (DTP), an outpatient program with centers in four locations across the county. DTP was designed to require 1 year's participation, during which the offender would proceed through three phases of treatment: detoxification, counseling, and educational/vocational assessment and training.

Among other aspects of the program, Goldkamp and Weiland examined treatment outcomes, which they classified as "favorable" or "unfavorable." Of 245 DTP participants, 40 percent had unfavorable outcomes (dropped out, disappeared, or were terminated for noncompliance) and 60 percent had favorable outcomes (graduated from DTP or successfully completed diversion according to court records). Offenders with favorable outcomes spent an average of 364 days in the treatment program, while those with unfavorable outcomes averaged 225 days. The investigators compared the 245 DTP participants with other groups of offenders who were not eligible or not assigned to DTP. DTP participants showed much lower rates of rearrest than offenders in the comparison groups; those who were rearrested averaged two to three times longer to first rearrest. Thus, the Dade County drug court program had an important effect on reducing the criminal caseload of the circuit court.

Coerced Treatment: For and Against

Several studies indicate that clients who enter AOD treatment because they are forced to do so by the criminal justice system make as much progress as those who enter treatment voluntarily. However, some researchers are opposed to coerced treatment on philosophical or constitutional grounds, and there are clinicians who believe there is little benefit to forced treatment.

Community-Based Drug and Crime Reduction Initiatives

Several States have developed community-based treatment programs that refer AOD-involved offenders to treatment in lieu of prosecution. Offenders who are on probation and who face revocation of probation (that is, return to jail for violation of the terms of probation) can also be referred to treatment. The most well-known example of this approach is the Treatment

Alternatives to Street Crime (TASC) program, which was initiated in 1972 and currently is used in 130 programs in 25 States ([Cook and Weinman, 1988](#); [Inciardi and McBride, 1991](#)). TASC identifies, assesses, and refers drug-involved offenders to community treatment services as an alternative or supplement to existing criminal justice sanctions.

After referring the client to community-based treatment, TASC monitors progress and compliance, including drug abstinence, employment, and personal and social functioning. Dropping out of treatment or other noncompliance is handled by the courts as a violation of the conditions of release (that is, terms that must be met while on community supervision), and the individual is returned to criminal justice processing.

The National Institute on Drug Abuse has been involved in a 3-year evaluation of TASC. Most TASC programs have carried out their treatment-outreach function successfully. [Sells \(1983\)](#), for example, reported that 50 percent of offenders referred to treatment by TASC were entering treatment for the first time, an important finding that demonstrated that TASC's outreach efforts were effective in targeting untreated offenders. Other independent evaluations also concluded that local TASC programs effectively intervened with clients to reduce drug use and criminal activity ([Inciardi and McBride, 1991](#)).

The most extensive although limited evaluations of the impact of TASC have been based on analyses of data from the Treatment Outcome Prospective Study (TOPS). TOPS is a longitudinal survey of 11,000 drug abusers in 10 cities; the study examined treatment outcomes, including renewed criminal activity of offenders after treatment. These studies compared clients involved in the criminal justice system -- in TASC and under other forms of criminal justice supervision -- with clients who voluntarily entered drug treatment; clients were compared on a variety of characteristics and behaviors. TASC clients improved to the same degree as voluntary clients with respect to drug use, employment, and criminal behavior during the first 6 months of treatment. TASC clients also remained in residential and outpatient drug-free treatment programs 6 to 7 weeks longer than voluntary clients or those with other types of criminal justice referral. Thus, TASC clients tend to participate longer in treatment, a factor that has been associated with better treatment outcomes.

Another community-based effort to reduce drug use and crime is intensive supervised probation or parole, known as "ISP" ([Petersilia, 1987](#); [Petersilia and Turner, 1990](#); [Petersilia et al., 1992](#)). ISP programs are not all designed specifically to treat drug users. However, these programs have features that might be expected to reduce drug use and recidivism; for example, probation or parole officers in ISP programs generally have low caseloads, allowing for close supervision of offenders; random drug testing is required. Early evaluations of ISP programs found the rearrest rates to be 10 percent or lower ([Petersilia, 1987](#)). However, a more recent study of ISP programs in seven cities found that ISPs for drug offenders were no more successful than routine supervision in reducing recidivism ([Petersilia et al., 1992](#)).

However, the study reported wide variations across sites in recidivism rates, suggesting that the design, implementation, and management of individual programs may have a large impact on outcomes. Data from three ISP programs in California indicate that clients who participated in rehabilitation programs, including drug counseling, had lower levels of recidivism ([Petersilia and](#)

[Turner, 1990](#)). Given that many ISP clients in the study had difficulties obtaining drug treatment, it was not surprising that as many as 30 percent of new ISP arrests were for drug-related offenses.

Another evaluation of five ISP programs in various parts of the country found that, although ISP offenders were tested for drugs more frequently than offenders under routine supervision, test results were similar for the ISP offenders and the routinely supervised groups: more than 50 percent tested positive for drugs during the 1-year followup period ([Turner et al., 1992](#)). Although ISP programs do not appear to differ significantly from routine supervision in reducing recidivism and drug use, it should be noted that most of the recidivism among ISP offenders was due to technical violations of parole or probation conditions -- resulting from increased supervision -- rather than arrests for new crimes.

Civil Commitment

One early approach to treatment within the criminal justice system is civil commitment. Developed in the 1960s, civil commitment was a legal procedure that permitted people addicted to drugs to be committed to compulsory drug treatment programs that typically involved a period of residential care and community-based aftercare. This approach provided the benefits of rehabilitation, while reducing the demand for drugs during both treatment and aftercare phases.

The California Civil Addict Program (CAP), an early program of this type, also was the most successful and the most studied. One study ([McGlothlin et al., 1978](#)) compared the outcomes for 1) addicted persons admitted to CAP and subsequently released to community supervision, with the outcomes for 2) addicted persons who were discharged from the program after a short period because of legal errors in the commitment procedures. During the 7 years after commitment, CAP clients reduced their daily narcotics use by 21.8 percent, while comparison clients reduced their daily use by only 6.8 percent. Furthermore, criminal activities among the civilly committed group were reduced by 18.6 percent, while the discharged group reported a reduction of only 6.7 percent. Thus, civil commitment as implemented in the California CAP reduced daily narcotic use and associated crime by program participants to one-third the levels among other addicted people not in the program.

Drug Courts

As discussed in [Chapter 1](#), recent efforts to deal with the increase in drug-related cases in the Nation's courts have resulted in the creation of drug courts -- special courtrooms dedicated to providing substance abuse treatment to individuals under close supervision of a judge. Proponents of these programs regard drug use, possession, and sale not only as a law enforcement problem but also as a public health problem that has deep roots in society. Proponents of the model argue that solutions to the drug crisis are more likely to lie in using AOD treatment to effect a long-term amelioration of the problem than in using strictly punitive approaches.

Successful Drug and Crime Reduction Programs

- Treatment Alternatives to Street Crime (TASC)
- Intensive supervised probation (ISP)
- Civil commitment
- Drug courts.

In drug court programs the court plays a role that goes well beyond the traditional one; as much emphasis is placed on effective AOD treatment as on adjudication of cases. The conviction that treatment works -- not in every case, but often enough to make this a better approach for some types of cases -- is a key premise of the programs.

Treatment for Incarcerated Offenders

Prisons

A major study of drug treatment provided in prison -- an evaluation of the Stay'n Out therapeutic community for offenders at two New York prisons ([Falkin et al., 1991](#); [Wexler et al., 1990](#)) -- had three major findings:

The Stay'n Out group had lower arrest rates than a comparable no-treatment group during the followup period.

- The Stay'n Out group had lower arrest rates than comparable groups exposed to other prison treatment approaches, such as milieu therapy or counseling.
- For the Stay'n Out clients, success after release was directly related to the length of time they remained in the program, although positive effects dropped off for those in treatment more than 12 months.

For example, after release on parole, only 27 percent of the male subjects who had been in Stay'n Out were rearrested, compared with 41 percent of those who had received no treatment while in prison. Stay'n Out clients who stayed in treatment for less than 9 months were almost three times more likely to be reincarcerated within 3 years after release than those who remained in treatment for 9 to 12 months. For offenders receiving other types of prison treatment, reincarceration was not related to time spent in treatment. There were fewer differences between outcomes measures for women in the various programs than for men. Overall, the evaluation of Stay'n Out established that prison-based treatment based on a therapeutic community model can result in significant reductions in recidivism rates.

Two evaluation studies of the Cornerstone program, a modified therapeutic community for offenders at the Oregon State Hospital, examined the effectiveness of the program and reviewed various treatment outcomes, including recidivism. The first study ([Field, 1985](#); [Gerstein and Harwood, 1990](#)) compared outcomes of Cornerstone graduates with three other groups: program dropouts, Oregon parolees with histories of drug abuse, and a similar group of Michigan parolees.

After 3 years, Cornerstone graduates had greater success rates than the other groups on two main

outcomes measures -- not returning to prison and not being convicted of any crime. Seventy-one percent of Cornerstone graduates did not return to prison during the 3-year followup period, and 54 percent were not convicted of any crime. The percentages for Oregon parolees, who had the next-best outcomes, were 63 percent and 36 percent, respectively. These differences are greater than they appear since Cornerstone graduates had more severe criminal and substance abuse histories than the parolee group.

In the second evaluation of Cornerstone ([Field, 1989](#)), outcomes for program graduates were compared with those of three program dropout groups defined by length of time in program (at least 6 months, 2 to 5 months, and less than 2 months). The results were similar to those of the earlier evaluation. For example, 3 years after program completion, 37 percent of Cornerstone graduates had no arrests, 51 percent had no convictions, and 74 percent had no time in prison. The 6-month dropout group had worse outcomes: only 21 percent had no arrests, 28 percent had no convictions, and 37 percent had no time in prison. The other two dropout groups had the worst outcomes.

Jails

A number of jails have recently developed substance abuse intervention programs for inmates, often with funding from the Bureau of Justice Assistance (BJA) or the Center for Substance Abuse Treatment (CSAT). The substance abuse treatment program operated by the Hillsborough County Sheriff's Office in Tampa, Florida, is one jail intervention program that has been evaluated ([Peters et al., 1992b](#)). During the course of treatment, program participants demonstrated significant improvement in their perceived ability to handle community high-risk situations and in their knowledge of issues related to relapse prevention and coping skills. More important, in the year after treatment, inmates who had been involved in the substance abuse treatment program remained in the community an average of 221 days before arrest, compared with an average of 180 days for the untreated offenders. During the 1-year followup period, treated inmates also had fewer arrests than the comparison inmates (an average of 1.1 arrests versus 1.5) and spent fewer days in jail (an average of 32 days versus 45 days). In addition, the arrest rates of the treated group decreased relative to their preincarceration arrest rates, while the rates for the untreated group increased.

Summary

In summary, this overview of research studies of outcomes for substance-abusing offenders indicates that AOD treatment interventions can be effective in a variety of settings in reducing relapse and recidivism and in producing desired changes in psychosocial behavior. As discussed in [Chapter 1](#), the results of the California Drug and Alcohol Treatment Assessment (CALDATA), a long-term study of treatment outcomes published in 1994, have provided strong confirmation of earlier findings on the effectiveness of treatment in reducing crime and recidivism. The CALDATA study found that in the year after AOD treatment, crime was reduced by two thirds. The greater the length of time spent in treatment, the greater the percent reduction in crime. In effect, there was a daily trade-off: each day of treatment paid for itself (the benefits to taxpaying citizens equaled the costs) on the day it was received, primarily through avoidance of crime.

Costs and Funding

Any strategy discussion eventually leads to the question: How will additional services be funded? Funding AOD abuse treatment for clients in the criminal justice system requires dedicated financial outlays. New funding sources may become apparent when developing joint approaches. Funds can be reallocated to establish or support programs where they are needed without new financing. In determining costs of treatment, services can be considered not only for what they cost to deliver, but also as a cost offset. That is, what future costs will be avoided if these services are successful?

The Scope of the Problem

A survey conducted by the Department of Justice in June 1994 revealed that the number of men and women in Federal and State prisons had topped 1,000,000 for the first time. The prison population grew by 40,000 in the first 6 months of 1994 alone -- equivalent to 1,500 new prisoners per week. This figure does not include the number of persons in jails -- estimated to be about 500,000 ([Holmes, 1994b](#)).

According to [Bureau of Justice Statistics \(1993b\)](#) the State and Federal prison population in the United States has been growing at an annual rate of 7 percent for 3 years, growth that is largely attributable to mandatory sentencing, especially for drug offenses. In 1980, for every 1,000 people arrested for AOD-related offenses, 19 were sent to prison. By 1992, this figure had risen fivefold, to 104 per 1,000 (Holmes, 1994a). If the present prison population continues to grow at 7 percent, four new 500-bed prison facilities will be needed each week to house all of the prisoners in the United States. In 1992, the United States spent an estimated \$6.8 billion on the construction of new prisons; more than 120,000 new prison beds were added in 1993 ([Edna McConnell Clark Foundation, 1993](#)). The national crime bill, passed in late 1994, provided \$8.7 billion for State prison construction.

California estimates that it will have to add 20 new prisons to the State's 58 to handle the increased number of inmates under California's new "three-strikes" law. Florida, which has doubled prison construction spending in the past 4 years, plans eight new prisons. Texas will open a new corrections installation each week for the next 18 months. Since 1982, the number of Federal prisons has risen from 43 to 77; yet these facilities house 30 percent more inmates than they were designed to accommodate. Forty-one States have put either the entire prison system or one or more major institutions under court order to alleviate overcrowding or poor delivery of services to inmates (Holmes, 1994a).

The cost of construction for new prisons averages \$54,209 per bed for State facilities and \$78,000 for Federal facilities. (New York State reported that the cost of a single communicable-disease cell for an offender infected with tuberculosis cost \$450,000. In 1991, the Federal Government ordered New York State to build 84 of these cells.) Financing and debt servicing costs boost the price tag on prisons. A 1990 study by the New York State comptroller found that the cost of building a maximum security bed was \$94,000, but with financing charges, the cost rose to \$246,783 -- a threefold increase ([Edna McConnell Clark Foundation, 1993](#)).

Operating costs for prisons are approximately \$4.5 billion per year; costs vary among States and types of facilities, averaging between \$9,500 and \$32,000 per inmate per year. In New York City, where labor costs are high, \$58,000 per year is required to keep an inmate in jail. According to the National Council on Crime and Delinquency, over a 30-year period -- about the length of a life sentence -- the cost of building and operating the average prison bed is \$1.3 million.

Current Operating Costs for Prisons

- Operating costs for prisons are approximately \$4.5 billion a year.
- The average cost to a State for an inmate every year varies from \$9,500 to \$32,000.
- Education and mental health services can add \$12 million a year to the total cost paid for by State agencies other than the corrections department.
- Over a 30-year period, the average cost of building and operating one prison bed is \$1.3 million.

In some States, operating costs are beyond the reach of State budgets. A January 1992 survey by the National Institute of Corrections found that, nationwide, 12,814 beds were completed but not open because of lack of funds.

Many prison expenses are paid by State agencies other than the corrections department -- expenses such as education and mental health services -- and taken together, they raise the real operating costs. A 1989 study in Alabama examined such costs and found they added \$12 million per year to the total cost of operating the system.

The costs of building and operating these needed correctional facilities can be contrasted with the costs of establishing AOD abuse treatment programs in correctional facilities. The Federal Bureau of Prisons has recently reported that it has costs of about \$2,100 per inmate per year to provide AOD abuse treatment to offenders (this figure does not include the costs to operate the facilities and largely reflects the costs of salaries). In Illinois, a 250-bed therapeutic community housed within a medium security prison costs approximately \$790,000 annually, or about \$3,200 per inmate per year (personal communication, Illinois Department of Alcohol and Substance Abuse, December 1994). These costs include a process-and- outcome evaluation and postrelease case management. (No capital costs associated with program startup, incarceration, or security are included.)

The costs of building new correctional facilities can also be contrasted with the lower costs of providing community-based treatment to nonincarcerated, nonviolent offenders who are being supervised in the community. Such arguments can be very convincing in appeals to legislatures for annual appropriations, and the criminal justice and AOD treatment fields can join forces for this purpose.

Costs of Establishing AOD Treatment Programs in Correctional Facilities

- AOD abuse treatment for one offender costs about \$2,100 a year.
- One therapeutic community housed within a medium security prison costs approximately \$3,200 a year for each inmate. (No capital costs associated with program startup, incarceration, or security are included.)

Reallocation

The basic premise of reallocation is that front-end investment in programs such as early AOD intervention will produce savings and decrease future treatment costs. Perhaps even more significantly, effective AOD treatment and prevention can keep AOD-abusing offenders from engaging in future criminal activity.

Cooperation between the criminal justice and AOD treatment systems regarding the allocation of treatment funds can have clear advantages for both systems. A portion of funds earmarked for quality control in a correctional institution might be allocated to support quality control of the institution's AOD treatment program. Also, reallocating funds for expanded AOD community treatment could decrease the need for additional prison beds. However, political forces often create barriers to major reallocations of funds.

Cost Offsets

The recently published CALDATA study described earlier in this chapter showed that every dollar invested in treatment saved \$7.14 in future costs, largely because of reductions in criminal activity during treatment and in the 2 years following treatment ([California Department of Alcohol and Drug Programs, 1994](#)). The investigators in the CALDATA study found that treatment affected criminal activity in two ways -- directly and indirectly. They pointed out that a person in treatment generally was introduced into new "reference groups" that provide new moral and ethical standards to substitute for reference groups and standards that had helped to engender past criminal activity. Treatment can indirectly affect criminal activity by reducing the economic motivations for crime; crimes are often committed to obtain money to buy alcohol and other drugs.

The CALDATA study also found significant cost offsets in healthcare utilization. AOD treatment improved health on several indicators and reduced future hospitalizations and outpatient medical visits. Healthcare benefits in the first year after AOD treatment offset about 55 percent of the cost of an AOD treatment episode. Persons treated in less expensive outpatient programs realized the same health benefits as those treated in more intensive residential settings.

Although these data on cost offsets are impressive, cost offsets are not guaranteed for every AOD treatment program in every correctional facility or outpatient setting. To effectively incorporate AOD treatment into all stages of the criminal justice system, many upfront costs are involved. For example, there are start-up costs associated with introducing treatment staff into a criminal justice setting. In addition, residential treatment programs, which provide intensive services, are expensive to operate. In the CALDATA study, almost half of the total funds invested in treatment in the State in 1992 were spent on treating only 15 percent of the total

treatment population -- in residential programs. However, the study also found that the greatest long-term benefits were derived from the most expensive programs (i.e., residential treatment). Ongoing evaluation research will play a significant role in determining which treatments are most effective with which subgroups of offenders. Carefully designed research is needed in order to provide planners and policymakers with reliable data for making decisions about funding. [Chapter 9](#) of this TIP describes approaches to measuring treatment outcomes.

New Funding Sources

When representatives from the criminal justice and AOD abuse treatment systems approach funding sources jointly, potential funding sources may be broadened. Some innovative strategies have been used to increase funds available for treatment:

- Many jurisdictions offset supervision costs by charging offenders for their treatment. Such an approach may not be realistic in all instances, since a large proportion of offenders are indigent.
- Resources recovered from confiscation and forfeiture of offender assets should be considered as treatment-funding possibilities.
- Minimum security work-release treatment centers can be set up to pay for themselves by using offender payments.
- Many jails and prisons have Inmate Welfare Funds, which must be used in programs that benefit inmates. Funds are usually generated through inmate phone commissions and commissaries.
- Federal, State, and private philanthropic funding might be available for creatively designed demonstration programs, especially funding sources that encourage systems coordination.

For example, CSAT has funded a variety of demonstration projects in several States to expand and enhance treatment for substance abusers under criminal justice supervision. All projects incorporate the CSAT comprehensive care model (as described in [Chapter 5](#)) and a continuum of treatment, health, and mental health services for incarcerated and nonincarcerated offenders. The projects support interagency criminal justice and human services linkages.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Chapter 3 -- The AOD-Involved Offender ¹

To provide effective services to clients in the criminal justice system, alcohol and other drug (AOD) abuse treatment providers must understand the special characteristics of this population. This chapter describes selected characteristics of individuals who become involved in the criminal justice system and who are also AOD abusers. Characteristics and related issues discussed include culture, ethnicity, gender, and the occurrence and impact of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), tuberculosis (TB), mental disorders, sexual abuse, and violence.

Overview

Program planners should recognize that AOD-involved offenders are not a homogeneous group. There are differences among offenders, even among those of the same age and gender who have the same cultural, ethnic, social, and economic backgrounds. These differences include personality, patterns of AOD abuse, health status, socialization, education, family, job training, urban and rural influences, and mental functioning. Offenders also range from seriously antisocial individuals who prey on people in their communities, to those who are more prosocial and have family and community support systems. The latter offenders usually find themselves involved in the criminal justice system as a result of situational or drug-related offenses. Very often, their only shared characteristics include involvement with alcohol and other drugs and the criminal justice system.

While there always have been AOD-involved offenders in the criminal justice system, their number has increased dramatically over the last 12 to 15 years as a result of increased drug-related crime, Federal and State legislation, and mandatory sentencing. Today the majority of offenders, regardless of the type of charges against them, appear to be involved with alcohol and other drugs. Estimates vary, but State correctional administrators generally report that 70 to 80 percent of inmates are involved with AODs. Among State prison inmates, about one-third were under the influence of alcohol when they were apprehended by the criminal justice system, and data from the National Survey of State Prison Inmates indicate that 25 percent admitted injecting drugs for nonmedical purposes. Local jails also have high proportions of inmates involved with AODs. About 60 percent of offenders were using drugs when they came into contact with the justice system; one half had used cocaine, and one third had used cocaine or crack regularly.

About one third of the crack users were in prison for violent offenses. About one fourth of offenders used heroin, and one in seven used heroin regularly.

Culture and Ethnicity

Offenders are most likely to be young males, primarily members of cultural and ethnic minority groups, and to have low educational attainment. Two thirds of offenders are under 35 years old, according to two 1991 Federal inmate surveys, one of people in State institutions and one of individuals in Federal facilities. These studies found that 22 percent of the inmates were under 25 and 46 percent were aged 25 to 30. The study also found that 95 percent of the offenders were men. (Although women constituted only 5 percent of the prison population, they also were the fastest growing segment of offenders.) The racial and ethnic data showed that 65 percent of the inmates were members of minority groups (46 percent African American, 17 percent Hispanic, and 2 percent "other") and 35 percent were Caucasian. Only one quarter graduated from high school, although about 60 percent received either a high school diploma or its equivalent.

AOD-involved offenders are not a homogeneous group. Differences are found, even among those people of the same age and gender who have the same cultural, ethnic, social, and economic backgrounds. Differences include personality, patterns of AOD abuse, health status, socialization, education, family, job training, urban and rural influences, and mental functioning. Very often, their only shared characteristics include involvement with alcohol and other drugs and the criminal justice system.

African American males now are involved in the criminal justice system at a higher rate than white and Hispanic males. While many of the reasons for this disparity in racial incarceration rates are due to factors outside the criminal justice system, evidence suggests that criminal justice practices and policies contribute to the differences. [Meier \(1992\)](#) reported that while rates of drug use among whites and African Americans vary only slightly (10.8 percent for whites versus 9.3 percent for African Americans), African Americans are arrested for drug crimes at far higher rates than whites (1,440 per 100,000 African Americans versus 302 per 100,000 whites), and the rate of drug-related arrests for African Americans increased at five times the rate for whites between 1972 and 1989. (The rate for whites increased 54 percent during that time versus 272 percent for African Americans.)

[Meier \(1992\)](#) also reported that 75 percent of regular drug users were white, 17 percent were Hispanic, and 8 percent were African American, but 43 percent of those imprisoned on drug charges were African American, 25 percent were Hispanic, and 25 percent were white. This pattern of differences was also found in a California study of plea bargaining practices that analyzed 700,000 criminal cases and concluded that "at virtually every stage of pretrial negotiations, whites are more successful than nonwhites in lessening the charges against them" ([Schmitt, 1991](#)). Of 71,000 adults with no prior records who were arrested on felony charges from 1989 to 1990, one-third of the whites had charges reduced to misdemeanors or infractions, while only one quarter of the African Americans and Hispanics were able to have their charges reduced. (An infraction involves breaking a rule -- such as a program rule or condition of probation -- not a law.)

Hispanic inmates were more likely than other inmates to have used drugs in the month prior to their offense (54 percent versus 49 percent). While Hispanic (34 percent) and white (32 percent) inmates were almost equally likely to have been under the influence of a substance at the time of their offense, African American inmates were less likely to be under the influence (29 percent). Twenty percent of Hispanic inmates reported getting money for drugs as a reason for committing their crimes, compared with 15 percent of white inmates and 17 percent of African American inmates.

A 1992 study by Meier reported that 75 percent of regular drug users were white, 17 percent were Hispanic, and 8 percent were African American; however, 43 percent of those imprisoned on drug charges were African American, 25 percent were Hispanic, and 25 percent were white.

The popularity of crack cocaine over the last decade has grown among all groups of drug users. However, African Americans are more than twice as likely as whites to use crack cocaine (14 percent versus 6 percent) ([Bureau of Justice Statistics, 1993a](#)).

Women

Women primarily enter the justice system when apprehended for nonviolent criminal activity arising from economic motives. These crimes include drug dealing, shoplifting, forgery, larceny, and prostitution. In 1993, 2.5 million women were arrested; about 500,000 of these arrests were related to alcohol and other drug charges ([Bureau of Justice Statistics, 1994](#)). The number of incarcerated women has tripled in the past decade, largely as a result of mandatory minimum sentencing for drug offenses. Currently, there are about 50,000 women in State and Federal prisons and 41,000 women in jails. Women are more likely than men to be serving sentences for drug offenses. About one third of female State prisoners and two thirds of female Federal prisoners are serving sentences for drug offenses ([Bureau of Justice Statistics, 1994](#)). Women are also more likely than men to have used heroin or cocaine both daily and in the month preceding their offense ([Bureau of Justice Statistics, 1994](#)). Mandated sentencing without the parallel development of services to address the needs of special populations has had a devastating impact on women in prisons.

Most women who are incarcerated are low-income, single heads of households with dependent children. Most are unemployed prior to incarceration. A large proportion come from families in which there is a pattern of incarceration over generations. More than 40 percent of incarcerated women report being physically or sexually abused before age 18. Approximately one in four women is either pregnant or postpartum when she enters prison; many women who enter prison have multiple medical problems, including problems related to pregnancy, HIV/AIDS and other sexually transmitted diseases, and TB ([Smith, 1993](#)).

Most women who are incarcerated are low-income, single heads of households with dependent children. Most are unemployed prior to incarceration. A large proportion come from families in which there is a pattern of incarceration over generations. More than 40 percent of incarcerated women

report being physically or sexually abused before age 18. Approximately one in four women is either pregnant or postpartum when she enters prison; many women who enter prison have multiple medical problems, including problems related to pregnancy, HIV/AIDS and other sexually transmitted diseases, and TB.

Women in all stages of the criminal justice system create a variety of special challenges. Infants born to addicted mothers have much higher morbidity and mortality rates than those born to women who are not substance users. Women need prenatal care, particularly high-risk pregnancy care. Providers in both the criminal justice and AOD treatment systems who supply services for pregnant women need guidelines for addressing their needs. For example, detoxification from methadone or other drugs is risky during pregnancy.

In about one third of cases, incarceration of women with children requires child protective services and other social agencies to become involved in out-of-home child placement because there are no relatives to assume childcare responsibilities ([Smith, 1993](#)). Many female addicts choose not to enter treatment for fear of losing their children, and this choice in many cases leads to further involvement with the criminal justice system. Inpatient or residential treatment also may involve placing children for extended periods. Outpatient AOD treatment programs have long recognized the need for providing childcare services, as well as a variety of other services, including transportation, medical care, and case management, to improve treatment retention of women. In addition, many women in the justice system lack parenting skills because they never received adequate parenting, in some cases because of multigenerational incarceration and out-of-home placement. Special training in parenting skills should be a component of an effective AOD abuse treatment program in a correctional setting.

The Center for Substance Abuse Treatment (CSAT) and other Federal agencies have recognized the need for improving access to care for women and providing needed services. The Federal interim block grant requirements, which State AOD treatment programs must fulfill before obtaining Federal funds, include special provisions for granting pregnant women priority access to treatment and for ensuring that women's special needs are met by AOD treatment programs. Another Treatment Improvement Protocol (TIP) in this series, *TIP 2: Treatment of Pregnant, Substance-Abusing Women*, specifically addresses special issues related to pregnant women. Other TIPs, for example, *TIP 1: State Methadone Treatment Guidelines, Matching Treatment to Patient Needs in Opioid Substitution Therapy*, and, *TIP 19: Detoxification for Alcohol and Other Drugs*, include extensive discussions of the methods for providing effective services to women.

Treatment programs in the criminal justice system should address the special needs of women by providing comprehensive services. Linkages with social service agencies and effective case management are key elements in providing the needed array of services. Approaches must take into consideration the fact that female offenders are often the sole caretakers of their children. Medical services for women are critical, since rates of chronic disease are higher among women entering the system than among men. Many women are victims of domestic violence and other types of violence, intimidation, and abuse, which has a significant effect on their ability to engage in treatment and their likelihood of relapse. Programs must address these issues of victimization directly and provide women with access to shelters and legal services to enable

them to gain safety. Housing and educational and vocational training are other needs that must be addressed.

However, most justice agencies lack adequate resources to deal with the influx of female offenders with this array of medical and social problems. Community collaboration is important in developing AOD treatment programs for female offenders, especially regarding issues such as housing, childcare, and child welfare and placement. Medical services are a critical treatment component. Psychiatric services are needed that address issues of guilt, remorse, and lack of self-esteem that are especially prominent among women entering AOD treatment. Women's partners should be involved in their treatment and case management whenever possible. Education in child rearing, including health and general homemaking, should be a component of treatment programs for female offenders.

Community collaboration is important in developing women's programs, especially regarding issues such as housing, childcare, and child welfare and placement.

Alternative sentencing for women, including work release programs, electronic monitoring, and day treatment centers, is important to avoid women's incarceration because it separates them from their newborns. When women are incarcerated, consideration also should be given to their need for contact with their children. (Such contact is also important for men.) Whenever possible, institutions should encourage children to visit their mothers during school vacations or holidays. For many female inmates, a prime incentive for entering AOD treatment is to regain custody of their children or to deliver their babies outside an institution. This goal may require not only arranging for early release, but also working with social service agencies and advocating for female clients. Because of these special needs, a strong argument can be made for selecting and training some case managers specifically to work with female offenders.

For nonincarcerated women in treatment, onsite childcare can be a strong motivator to complete treatment and can provide an opportunity to offer parenting training to improve mother-child relations. This approach benefits the children, who may receive better nutrition and healthcare than otherwise would be available.

HIV/AIDS

The incidence of HIV infection among incarcerated individuals is 10 times higher than the incidence in the general population. A 1992 survey of Federal and State prisons and large-city jails indicated that 195 of every 100,000 inmates were HIV positive ([Hammett et al., 1993](#)). The incidence rate in the general population is 18 persons per 100,000. There are large regional differences in HIV prevalence rates, with higher rates in urban areas on both coasts.

This elevated rate is largely attributable to needle sharing among injection drug users. According to the National Survey of State Prison Inmates, 40 percent of inmates who used drugs in the month before their offense had used a needle to inject drugs, and half of these people self-reported sharing needles. In addition, 12 percent of prison inmates admitted sharing needles

while incarcerated. Homosexual contact accounts for very few cases of AIDS among inmates; 2.2 percent of cases of HIV/AIDS among inmates are attributed to homosexual contact. Self-reported survey data from State and Federal prison inmates indicated that 2.2 percent were HIV positive ([Bureau of Justice Statistics, 1993c](#)). However, only 51 percent of those surveyed reported that they had been tested for HIV, 32 percent had never been tested, 9 percent did not know if they had been tested, 7.5 percent said they had been tested but had never learned the results, and only .1 percent refused to report their test results.

Of inmates who were tested for the presence of HIV and had their results reported, females (3.3 percent) were more likely than males (2.1 percent) to be HIV positive. Rates of HIV infection are higher among female prisoners than among women in the general population. The higher rates are related to prostitution, needle sharing, and unprotected sex. In addition, a review of data along ethnic and racial lines found that almost 3.7 percent of Hispanic inmates were HIV positive, compared with 2.6 percent of African American inmates and 1.1 percent of white inmates ([Bureau of Justice Statistics, 1993c](#)).

HIV must be addressed at every point of contact between the criminal justice and AOD treatment systems -- from arrest through incarceration and parole -- and across all age groups. As shown in the CSAT Criminal Justice Treatment Planning Chart([Appendix B](#)), infectious diseases risk assessment should be addressed along with assessment for AOD problems. Prevention education is a key component, and every effort should be made to help offenders understand risk factors such as needle sharing and unprotected heterosexual and homosexual contact. The link between injection drug use and HIV transmission is well known; however, the link between use of noninjection drugs such as alcohol and crack and unsafe sexual practices should be strongly emphasized.

A critical factor in the prevention of further HIV transmission in this population is HIV and risk factor education and training of personnel in both the criminal justice and AOD abuse treatment systems. Such training is particularly important to ensure that HIV-infected offenders have equal access to treatment. [Chapter 7](#) includes a discussion of training topics related to HIV/AIDS and other infectious diseases. A separate TIP in this series, TIP 15: *Treatment for HIV-Infected Alcohol and Other Drug Abusers*, provides treatment guidelines and discusses the needs and health problems of this treatment population.

Assistance to offenders should be comprehensive, including prevention education, medical and social service support, and grief counseling and other psychological services. Services should incorporate screening, support services, medical interventions such as primary care, and family counseling. In addition, continuing care should be provided and include followup and hospice care.

HIV must be addressed at every level of the criminal justice system. A critical factor in the success of preventing further HIV transmission in this population is education and training. Personnel in both the criminal justice and AOD abuse treatment systems should be taught about HIV/AIDS and its risk factors.

Tuberculosis

Tuberculosis in correctional facilities is not new. Historically, inmate populations contain disproportionate numbers of persons of low socioeconomic status, those with AOD problems, and people with generally high-risk and unhealthy life-styles and poor access to medical care. Prisons and jails are high-risk settings for the spread of TB infection: living conditions are generally crowded, and many buildings have antiquated systems with poor ventilation and air circulation.

Improvements in prevention and treatment of TB greatly reduced its incidence by midcentury and later. For example, from 1944 to 1948, the prevalence of TB in New York State correctional institutions was 1.2 percent for men and 0.7 percent for women; at the same time, the rate in the general population was significantly lower (0.3 percent) ([Katz and Plunkett, 1950](#)). Twenty years later, Hans Abeles, then head of Health Services for the New York City Department of Corrections, reported active tuberculosis among newly admitted inmates to Rikers Island to be 0.2 percent ([Abeles et al., 1970](#)).

However, in recent years the incidence of TB has risen dramatically, largely as a result of the appearance of a new, multidrug-resistant variety of TB. According to a recent estimate by the Centers for Disease Control and Prevention (CDC) as many as 133,000 persons with TB infection may be released each year from Federal and State correctional facilities ([Centers for Disease Control and Prevention, 1993](#)). In a widely publicized 1992 outbreak of multidrug-resistant TB, 36 New York State prison inmates and one correctional officer died. Ninety-eight percent of the inmates who died were also HIV infected. In response to the outbreak, New York instituted universal screening of inmates and developed a database to maintain all test results.

In late 1992, CDC and the National Institute of Justice conducted a survey of all 50 State correctional systems, the Federal Bureau of Prisons, and 37 large city and county jail systems. The survey found that, overall, 10 percent of male inmates and 12 percent of female inmates were TB infected; rates varied widely by geographic area. However, one third of the State and Federal systems and almost one half of the jail systems did not conduct routine skin tests for TB purified protein derivative (PPD) tests and therefore were not able to report prevalence rates. The CDC funds TB screening programs at selected correctional facilities where AIDS and TB cases are reported to be high. In these facilities, infection rates as high as 25 percent have been found ([Hammett and Harold, 1994](#)).

In 1989, the CDC issued guidelines for the prevention and control of TB in correctional facilities ([Centers for Disease Control and Prevention, 1989](#)). The guidelines address surveillance (screening, diagnosis, case reporting, and investigation of contacts), containment (isolation, treatment, and therapy to prevent TB-infected individuals from developing TB disease), and assessment (recordkeeping, case tracking, and ongoing evaluation of compliance with procedures). The guidelines also recommend centralized control and oversight of TB control efforts, both at individual institutions and systemwide.

As some policymakers have pointed out ([Glaser and Greifinger, 1993](#)), incarceration provides an opportunity for early detection and treatment of a variety of infectious diseases in an otherwise

elusive group whose risk factors and prevalence rates far exceed those of the general population. It is more feasible to screen inmate populations and to ensure that they complete a course of preventive therapy or treatment than it is to carry out similar interventions in the community with high-risk populations.

Both inmates and staff should receive education about TB and how to prevent it. Although TB is transmitted through the air, fairly intensive exposure is required for transmission to occur. Inmates and staff should understand the importance of completing courses of medication. [Chapter 7](#) describes specific training topics and resources for staff training.

Mental Disorders

Mental illness is diagnosed among a significant number of offenders who have AOD disorders. Researchers ([Regier et al., 1990](#)) examined data from the general United States population and reported that 30 percent of adults who had ever had a mental disorder also had a diagnosable substance use disorder during their lives. More than one half were addicted to drugs other than alcohol. Thirty-seven percent of those who were alcohol abusers had one or more mental disorders. A significant number of substance abusers experience severe emotional problems, including bipolar disorder, unipolar depression, and schizophrenia. Lifetime rates of depression of up to 75 percent have been detected among drug abusers ([Mirin et al., 1988](#)).

AOD abusers with mental illness have been involved in correctional settings for years. However, it has been only in the last 5 years that researchers, policymakers, and care providers have focused on the need to address coexisting AOD and psychiatric disorders (dual disorders) in correctional populations. Twenty-five percent or more of addicted offenders have lifetime histories of major depression, bipolar disorder, or atypical bipolar disorder, and 9 percent have histories of schizophrenia ([Chiles et al., 1990](#); [Cote and Hodgins, 1990](#)). These are serious chronic mental illnesses that produce significant dysfunction if not treated.

In metropolitan jails, the prevalence rates of mental illnesses are much higher. [Abram \(1990\)](#) reported that 44 percent of jail inmates had lifetime prevalences of substance use disorders combined with either depression or antisocial personality disorders. [Peters and fellow researchers \(1992a\)](#) found that inmates with "high psychopathology" reported significantly more lifetime use of amphetamines, hallucinogens, and heroin, in addition to slightly more alcohol and cocaine use in the month prior to prison entry.

Substance abusers with mental illness who also are criminal offenders have special problems and need access to coordinated mental health services. Sometimes, mental health programs may not admit patients with dual disorders because of their substance abuse, and AOD treatment programs may not admit substance abusers because of their mental illnesses. Thus, arranging for treatment for these clients is particularly difficult and challenging.

AOD treatment and mental health programs should work together to focus attention on this segment of the offender population that often is not appropriately served. Mental health professionals should be involved in the case management of coordinated and continuous

treatment. Another TIP in this series, TIP 9: *Assessment and Treatment of Patients With Coexisting Mental Illness and AOD Abuse*, focuses on these issues.

Sexual Abuse and Violence

Violence is an integral part of many AOD-involved offenders' lives. Many are perpetrators of violent behavior, and many more are victims. Issues related to victimization can interfere with AOD treatment. In particular, women offenders are often victims of physical, sexual, and emotional abuse -- both as adults and as children. Counseling provided in AOD treatment programs for offenders should focus on issues related to violence, such as domestic violence, anger and impulse control, and a history of physical and sexual abuse. Once treatment progress is made, feelings of guilt and remorse frequently surface, and individuals need support to address these issues. Anger management training can enhance the support. Sex offenders often are violent offenders and victims of violence, and they need special treatment in addition to AOD abuse treatment. They face issues that are similar to those faced by people with dual disorders, and these issues can greatly complicate substance abuse treatment efforts. Strategies are needed to determine when these clients should receive AOD treatment and how it can be integrated with sex offender treatment. Other considerations include the provision of specialized AOD treatment and support groups for sex offenders and assurance that confidentiality is protected.

Treatment Alternatives to Street Crime (TASC) has developed a model program that is designed to effect positive long-term attitude and behavior change in drug-involved adult and juvenile offenders. The Violence Interruption Process (VIP) helps individuals develop a broader understanding of the causes of violence and teaches them to apply that knowledge in their day-to-day environments. The program uses role-play, didactic presentations, group exercises, and discussion formats. The central assumption is that violence is not inherent to individuals or communities but is a learned behavior that can be unlearned. Respect for others, an understanding of societal interdependence, and a problem-solving approach are key elements of the program. Participants are encouraged to establish alliances in their communities to interrupt violence. VIP has been used effectively with a variety of groups.

It has been only in the last 5 years that researchers, policymakers, and care providers have focused on the need to address coexisting AOD and psychiatric disorders (dual disorders) in correctional populations. Twenty-five percent or more of addicted offenders have lifetime histories of major depression, bipolar disorder, or atypical bipolar disorder, and 9 percent have histories of schizophrenia. These are serious chronic mental illnesses that produce significant dysfunction if not treated.

Issues related to victimization can interfere with AOD treatment. In particular, women offenders are often victims of physical, sexual, and emotional abuse -- both as adults and as children. Counseling provided in AOD treatment programs for offenders should focus on issues related to violence, such as domestic violence, anger and impulse control, and a history of physical and sexual abuse.

Conclusions

There is no "representative or typical" offender. However, it is more likely that the offender is male, a member of a cultural or minority group, less than 35 years old, and has low educational attainment, low employability, and poor health. Major health problems for this population include substance abuse, consequences of injecting drugs, and HIV/AIDS, TB, and other infectious diseases. Many have psychiatric disorders in addition to substance abuse disorders. Additional problems are faced by female offenders, particularly those who are pregnant or have children, because the women need childcare assistance and have problems related to pregnancy, health, and victimization, often involving violence.

Challenges

One of the greatest challenges faced by both the criminal justice and AOD treatment systems is understanding the variations among offenders. With limited resources, the criminal justice and AOD systems are faced with serving increasing numbers of individuals while using program models developed to treat a white, male population -- these models are not directly transferable to other groups. Thus, new techniques and methods are needed to meet these requirements.

Endnote

1. This chapter was written for the Consensus Panel by Douglas S. Lipton, Ph.D.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Chapter 4 -- The Criminal Justice Continuum

To plan effective strategies for collaboration, alcohol and drug (AOD) abuse treatment system planners, policymakers, and providers must have a detailed understanding of the workings of the criminal justice system. Terms and concepts used in the justice system are often misunderstood by people outside the system. This chapter presents an overview of the criminal justice continuum, suggesting points at which linkages between the two systems can be created and strengthened.

An important supplement to the information in this chapter is the Center for Substance Abuse Treatment (CSAT) Criminal Justice Treatment Planning Chart, which is included in [Appendix B](#) of this document. The chart gives a simplified overview of the criminal justice continuum, showing the flow of cases through the system. The chart shows the major decision points in the continuum and where coordinated strategies for substance abuse treatment interventions may be applied. Accompanying the chart is a glossary of common terms and concepts used in both the criminal justice and AOD treatment systems. It is hoped that criminal justice and AOD treatment systems will adapt and use the chart as a planning and coordinating tool to improve AOD abuse treatment services.

Overview

Although there are Federal, State, and local differences, the criminal justice system can be viewed as a continuum, the stages of which involve personnel from various justice agencies. Throughout the stages of the continuum, efforts are focused on the common goal of protecting public safety. Major areas of criminal justice processing are

- Arrest
- Arraignment
- Plea bargaining (negotiations leading to disposition or trial)
- Diversion programs
- Trial
- Presentencing
- Sentencing
- Probation
- Intermediate sanctions

- Jails and prisons
- Parole or mandatory release.

To provide the most effective services, AOD abuse treatment providers must work within each phase of the criminal justice system. Personnel should focus on system points of contact at every possible juncture. An understanding of the case-flow process at every stage from arrest to release will enhance coordination. Ongoing communication for managing AOD-involved offenders is critical.

Supporting and Creating Linkages

Two other CSAT Treatment Improvement Protocols (TIPs) in this series describe diversion of certain individuals from the criminal justice system into treatment in the early stages of their involvement with the justice system. TIP 23: *Integrating Alcohol and Other Drug Abuse Treatment With Pretrial Processing of Criminal Cases and Combining Alcohol* and TIP 21: *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* address the many issues involved with linking the two systems. The former TIP describes the drug courts that have evolved over the years to handle the increase in drug-related arrests. The latter TIP describes a process of diverting juvenile offenders into treatment before they become entrenched in the criminal justice system.

In addition, a third TIP in this series, TIP 12: *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, provides detailed guidelines for creating linkages between the two systems primarily after adjudication (trial or sentencing).

Criminal Justice Referrals

Several different categories of criminal justice system personnel can refer an individual into treatment. However, persons in the AOD treatment system should recognize that the source of the referral is important because it determines whether the individual enters treatment voluntarily or is mandated into treatment. Also, different personnel in the justice system have different motives for referring an individual to treatment and thus will refer in different situations. For example, the bail commissioner may only refer individuals who otherwise would fill the jails, regardless of whether they have AOD problems. Judges tend to recommend treatment only if it relates to the current charge and falls within the requirement for the least restrictive environment. A public defender may refer to treatment only if it will help his or her client's case. If the client needs treatment, but the current charge is unrelated to alcohol or other drugs, there may be no referral because sending the client to treatment could negatively affect the case.

In many of these decisions, the system is focused on the present (and possibly the past) of the client and not on the larger issues of what is good for the client and society as a whole. Many who consider the big picture would say that it is better to get the individual into treatment (regardless of the charge) because recovery will not only improve the health of the individual but also result in decreased crime, safer streets, and reduced cost to society.

Stages in the Justice Continuum: Arrest and Pretrial

Arrest is the taking of a suspect into legal custody by police, probation or parole officers, and other authorized officials. Arrest may be authorized pursuant to a judicial warrant, which is issued when there is probable cause to believe that a crime was committed and that the suspect committed the crime. Arrest without a warrant may be made by a police officer when there is probable cause to believe a felony was committed and the suspect committed it. Arrests for misdemeanor violations generally require a warrant, except when the arresting officer sees the suspect committing the misdemeanor (for example, in some cases of drug possession). Police have some discretion in whether to make arrests, although several jurisdictions have mandated arrest in certain situations, such as domestic violence or drunk driving.

Following arrest, defendants enter the pretrial period. Typically, they appear before a magistrate in court, bond is set, and they are released under their own recognizance or a determination is made to retain them in jail or under supervision in a detention facility until their trial.

Ideally, police officers would use their community contacts to explore AOD treatment services options for AOD-involved individuals who come to their notice but are not arrested. For many individuals, further involvement in the criminal justice system might be prevented if police were empowered and informed about AOD abuse so that they could make referrals, and if the treatment system were willing to work with the referred clients. "Community policing," which is discussed more fully in [Chapter 6](#), is an approach to police involvement in the community that seeks to overcome negative relationships that arise when police officers are perceived as outsiders by community residents.

Being arrested can motivate some AOD abusers to enter treatment. From a treatment perspective, arrest and the related crisis may have a positive outcome. Arrest is a significant event in a person's life because it may make it difficult for him or her to deny AOD abuse problems. It offers the opportunity for the arrestee to voluntarily choose to enter AOD abuse treatment. Thus it is important for connections to be made between the treatment and criminal justice systems at this point. Representatives from both the criminal justice and AOD treatment systems can see arrest as an important place to set up linkages, begin intervention, and find ways of working together. From the perspective of criminal justice personnel, especially judges, an important aspect of these linkages must be the accountability of treatment providers to ensure that public safety is protected.

Arrest can be a significant event in a person's life because it may make it difficult for him or her to deny AOD abuse problems. It offers the opportunity for the arrestee to voluntarily choose to enter AOD abuse treatment. Thus it is important for connections to be made between the treatment and criminal justice systems at the point of arrest.

It must be noted, however, that involvement of AOD abuse treatment providers at the point of arrest may raise constitutional issues. If the arresting officer considers transfer of the individual to AOD treatment rather than to the criminal justice system (which has laws protecting

defendants' rights), questions may be raised about due process, civil liberties, and extension of the criminal justice system beyond permissible bounds. After arrest, the defendant is subject to the authority of the criminal justice system. The level of responsibility granted to the treatment program should be defined clearly, understood by both systems, and incorporated into the information flow between systems.

Pretrial information about a defendant can be grouped into the following categories:

- Criminal record
- Prior compliance with supervision
- Pretrial evaluation
- AOD abuse assessment information
- AOD abuse treatment information.

Basic information gathered about the defendant should follow the offender through subsequent stages of the criminal justice system and AOD abuse treatment system. Agencies from both systems should decide what information is necessary and useful, and should develop methods for sharing that information. However, the defendant's civil liberties and rights of confidentiality must be considered whenever information is shared. These legal issues are discussed more fully in [Chapter 8](#).

Arraignment and Plea Bargaining

Arraignment is a technical term signifying presentation of the charges to the defendant. In many jurisdictions the term *arraignment* is reserved in felony cases for the presentation of charges in the superior court. A first appearance is held in the lower court after arrest for bail setting and probable cause review. This hearing is not referred to as an arraignment.

The period of time between arrest and arraignment is a window of opportunity for intervening and articulating the value of AOD treatment. Drug testing, screening, and assessment for AOD abuse and dependence and for infectious diseases, needs assessment in other areas, and various forms of AOD treatment, as well as relapse prevention, are important components of intervention at this time as well as at other points along the continuum. A multidisciplinary approach is recommended, with treatment providers available to work with police and court personnel to guide drug-abusing offenders into treatment.

During the arraignment, charges are brought against the defendant, and the defendant is informed of his or her rights. The defendant then enters a plea in response. Additional personnel, including staff from pretrial service agencies, judges, prosecutors or defense attorneys, court referral officers, and representatives of referral systems, handle this process and become involved as the defendant moves through the arraignment process. Each of these individuals can refer the defendant to AOD treatment services.

With court overcrowding, plea bargaining is used in a large number of cases. In a plea bargain, defendants are allowed to plead guilty to lesser charges than the charges that they would have to face in a trial. Once the guilty plea is entered, it is up to the judge to determine a sentence.

Incorporation of substance abuse concerns into the plea bargaining process is a key element in strategies to link the justice and treatment systems. A requirement that the defendant enter treatment can be part of the plea bargain. Many systems are finding that getting defendants into treatment at this point is successful because they are ready for services. However, just as overcrowded court dockets force the hand of criminal justice system officials on certain decisions, overcrowded caseloads can make it impossible for treatment programs to accept new clients.

Incorporation of substance abuse concerns into the plea bargaining process is a key element in strategies to link the criminal justice and AOD treatment systems.

Presentencing

Presentencing is the period after a guilty plea is entered (in cases that are plea bargained) or after a conviction is handed down (in cases that go to trial).

Prior to sentencing, a *presentence investigation* is conducted. The investigation is conducted after the plea is entered or after the conviction is handed down. In some plea-bargained cases, a plea may be withdrawn after the presentence investigation is completed and sentencing recommendations are made.

Many jurisdictions have presentence investigation agencies, which specialize in writing the report. Elsewhere, probation officers compile the report. The sentence or penalty handed down by the judge is based on the information that has been compiled in the presentence report. Therefore, with more relevant information available, the judge will be better equipped to make an appropriate sentencing decision.

This is another point where linkages between the two systems are critical. It is suggested that some sort of AOD intake and preliminary assessment be provided at this stage, if one has not yet occurred in the earlier stages.

In many States, there are serious legal constraints on sharing information contained in the presentence investigation. In some States, only the judge can see the report -- not even the defendant can see it. However, the presentence investigation report may contain information highly relevant to developing an AOD treatment plan for the individual. To avoid duplication of efforts in gathering needed information at various stages of the justice-treatment continuum, planners should investigate ways to facilitate information sharing without breaching confidentiality and to ensure that critical information follows the individual through the process.

Drug Courts

Cooperative efforts between the two systems have already been undertaken in many jurisdictions in the form of drug courts and other efforts to divert some substance-abusing defendants into treatment rather than into extensive, costly, and often repeated involvement with the justice system. As discussed in [Chapter 1](#), drug courts are special courtrooms that integrate substance

abuse treatment and justice system case processing under close supervision of a judge. It is beyond the scope of this TIP to describe in detail the concepts and operations of drug courts and diversion processes. However, other TIPs in this series examine the cooperation of the two systems in these areas.

Trial

A *trial* is a court hearing in which a prosecutor presents a case against the defendant to show that he or she is guilty of an accused crime. A judge or jury decides the verdict. If the verdict is "guilty," the sentence or the penalty imposed in the case is determined by the judge, or, as in several States including Texas and Virginia, the jury determines the sentence. In many States, the sentence or penalty is based partially on the information that has been compiled in the presentence investigation report. Increasingly, States are passing laws to ensure that the penalty is based on the offense without regard to information contained in the report.

Sentencing

Sentencing is the disposition of a case in which penalties are imposed. Once the defendant is adjudicated (either by plea or jury trial), information in the presentencing report will generally be used to assist in sentencing decisions. The goals of sentencing are to reduce community risk and punish the offender fairly. Some States continue to recognize rehabilitation of the offender as a goal. Deterrence of crime by others by creating an example can also be thought of as a goal of sentencing. Although victim restitution is not a goal of sentencing, a judge may be authorized to require it.

Sentences can be fines, probation or incarceration, or a combination of the two. Sentencing can include house arrest, electronic monitoring, and other community sanctions. Sentencing can also be linked with AOD treatment without increasing the length of the sentence. Sentencing may include outpatient treatment, family therapy, medical care, or placement in a halfway house. In many jurisdictions, public and private agencies have created a wide variety of intermediate sanctions programs, which are described below in a separate section.

Some jurisdictions, such as the State of Colorado, have developed and are implementing a standard set of policies and procedures for offender treatment that includes the items the judge needs to consider in making a sentencing decision. Each offender is assessed and receives a validated assessment score that is used in recommending levels and types of treatment. In San Francisco, the probation staff periodically updates the court, both in writing and in person, about various treatment options that are available to the court at the time of sentencing.

In combining treatment with judicial sanctions, judges have to think creatively, look for innovative approaches, and possibly take risks. Some examples of successful approaches include intensive outpatient treatment, day reporting centers, intensive supervision, curfew or house arrest (with or without electronic monitoring), residential treatment and halfway houses, and boot camps. Judges need a policy that can be used as a basis for decisionmaking and that includes a menu of available options. (See the companion TIP Combining Substance Abuse Treatment

With Intermediate Sanctions for Adults in the Criminal Justice System for more discussion of these issues.)

Probation

Probation is a sentence of community-based supervision. Probation includes stipulations and prohibitions on certain activities and often includes fines imposed by the court at the time of sentencing.

Understanding the purpose and functions of probation requires an understanding of probation's place within the criminal justice continuum. Probation provides supervision for offenders while they engage in a community-based process intended to modify or change behavior. The efficacy of probation is measured by a reduction in the offender's criminal activity and by the offender's ability to perform productively in the community after completing probation. Constructive and positive change by the offender is a tangible demonstration that the system is working effectively. Probation's goals have been statutorily defined by both State and Federal legislative bodies. Probation officers are required to prepare written court reports, advise judges on sentencing recommendations, supervise offenders placed on probation by the court, and report to the court about the conduct and actions of offenders who violate probation.

Probation provides supervision for offenders while they engage in a community-based process intended to modify or change behavior. The efficacy of probation is measured by a reduction in the offender's criminal activity and by the offender's ability to perform productively in the community after completing probation.

Over the years, the role of probation has changed substantially. Probation was initially designed to carry out well-tailored community correction programs for nonviolent offenders. The goal was to aid in rehabilitation by providing a wide range of services for offenders who posed no risk to the community. This is no longer the goal. Increasingly, probation is used to supervise the activities of serious offenders whose needs are dramatically different from those of offenders 30 years ago. Today's probation officers can no longer be concerned with rehabilitation alone, but must be prepared to address offender risk management, crime control, correctional treatment, and habilitation. This change does not mean that today's caseloads are more violent. The great majority of offenders -- about nine out of ten -- who receive probation have not committed violent crimes. However, the needs of current offenders are more complex and require a greater array of specialized services, such as those used in supervising AOD-involved individuals.

Despite the growing emphasis on incarceration since 1980, probation is still the dominant sentencing sanction. [The Bureau of Justice Statistics \(1994\)](#) reported that in 1990, the last year for which data are available, the probation population represented more than 2.5 million offenders; this population has been growing at the rate of 13 percent per year. Although probation is the most frequently used sanction and is employed to supervise the most offenders, its effectiveness is often undermined by a lack of several kinds of support. Carrying out the goals

of probation is critically compromised in many jurisdictions by a lack of resources, inadequate funding, and significant reductions in personnel.

To be effective, probation must provide a meaningful sentence from among a range of options available to meet the needs of an increasingly diverse population. Probation officers have had to expand their roles as behavioral specialists in order to match the offender with an appropriate program. Increasingly, probation is being viewed as existing in two forms -- traditional probation and intensive probation. At least two levels of probation should be available to the judge, and supervision should be predicated on community safety and offenders' needs.

For probation officers working with AOD abusers, the maximum caseload suggested by the consensus panel that developed this TIP is 35 clients; this also is the caseload limit recommended by the Federal probation system. In many jurisdictions, however, the probation officer's caseload may be four times that number, an unmanageable size in terms of fulfilling recommended goals.

Although the role of the probation officer has changed in recent years, reflecting the diverse needs of offender populations, many aspects of the role remain unchanged. Probation is a legal disposition. Therefore, controlling, monitoring, surveilling, and enforcing the court-ordered conditions of probation should not be subordinated to the task of helping the offender, but should remain primary tasks. However, out of necessity, many have broadened this conception of the probation officer's role to include that of a case manager, with added responsibilities of bridging and linking systems to engage needed supports and advocating for the offender where appropriate. Probation officers have a critical role in linking the AOD and criminal justice systems.

While the probation officer can be viewed correctly as a behavioral specialist, it is important to note that the probation relationship is not a clinical one in the usual sense. First, a relationship between an adult client and therapist is in virtually all cases a voluntary one that the client can terminate at any time. In addition, except in certain well-defined circumstances, such as when a client reports abusing a child, the client-therapist relationship is protected by ethical and legal confidentiality requirements. (Issues surrounding offender's confidentiality rights are discussed in detail in [Chapter 8](#).)

For example, a client who seeks therapy for bipolar disorder might tell a therapist that he wrote bad checks during a manic episode. The therapist might deal with this issue therapeutically, by discussing the client's feelings about the behavior or its consequences, with the aim of helping the client avoid repeating these behaviors in the future. The client's confession of this criminal activity would reflect his understanding of the special nature of the clinical relationship, which would be encouraged by the therapist. However, if an offender told a probation officer that he had written bad checks, he would not have the same expectation. The probation officer must supervise the offender during probation and ensure compliance with court-ordered sanctions, and would have to report the incident.

It can be seen in these examples that the overall goal of helping the offender avoid criminal activity in the future is the same. When that goal is the focus, especially in jurisdictions that have

implemented collaboration between the criminal justice system and the AOD abuse treatment system, the roles of personnel in both systems are not as clear-cut as in the example provided. For true collaboration, there must be a blurring of roles, backed up by accountability. These issues are described more fully in subsequent chapters of this TIP.

Intermediate Sanctions

Sanctions are legally binding orders of the court or paroling authority that deprive or restrict offender liberty or property. An *intermediate sanction* is any sanction that is more rigorous (unpleasant, intrusive, or controlling) than traditional probation but less restrictive than total incarceration. With the advent of new technologies for supervision of offenders, new methods of intervention and treatment, and an increased understanding of targeting programs to particular populations, agencies have the means to safely manage and treat offenders in the community.

Another TIP in this series, TIP 12: *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, focuses exclusively on intermediate sanctions. The following discussion summarizes a few of the issues it addresses.

The particular programs or forms of sentencing that comprise a jurisdiction's intermediate sanctioning options can be determined by the policymakers of that jurisdiction, based on its needs and financial situation. Some of the more widely used options are described in [Exhibit 4-1](#). AOD abuse treatment may be combined with any of these sanctions to achieve the goal of more effective sentencing for AOD-involved offenders. It is important to understand, however, that each jurisdiction, whether a State, a county, or a court district, will have developed its own version of these, and that from area to area, programs may share a name and little else. Combining treatment and sanctions requires that all those with a stake in these programs -- criminal justice and treatment systems representatives and community and government representatives -- develop an integrated policy.

For some, these sanctioning options represent the right approach to sentencing. Many policymakers in the criminal justice system want the ability to determine individualized sentencing and to respond appropriately and effectively to the diversity of offenders and offenses presented to them. The interest of others is driven by profound dissatisfaction with the outcomes of most existing sanctions, including prison, jail, and probation, particularly in light of their cost. Dissatisfaction with current sanctions is probably deepest in cases that involve AOD-abusing offenders.

Others, including criminal justice officials and a considerable portion of the public, believe that intermediate sanctions are necessary because there is simply not enough money to build prisons to incarcerate all offenders. The public is beginning to understand that being jailed or imprisoned is not the only possible or appropriate consequence of criminal behavior. The public will accept creative approaches even for serious offenses and accepts the idea of restitution or meaningful community service, combined with AOD treatment, as appropriate for certain criminal actions.

The goal of intermediate sanctions must be more than merely making probation tougher or diverting offenders from prison. Effective intermediate sanctions for AOD abusers must be more

than a series of unrelated interventions. They should encompass a continuum of rationally graded sanctions and control options. The concept of *graduated sanctions* is a primary factor in the effectiveness of intermediate sanctions. Providing graduated sanctions involves increasing or decreasing requirements, levels of supervision, or limits on movement in order to ensure appropriate and consistent response by offenders. Some examples of graduated sanctions include

- Increasing community service hours
- Adding electronic monitoring to home arrest
- Switching from regular to intensive probation
- Tightening curfew hours.

When AOD abuse treatment is combined with intermediate sanctions, examples of graduated sanctions might include

- Requiring participation in a relapse program
- Increasing frequency of urinalysis
- Moving the offender to a more restrictive treatment program, for example, from an outpatient to a residential program.

Jail

A *jail* is a facility that holds both pretrial and sentenced offenders in lawful custody while they await trial, serve short-term sentences of up to 1 year, go on work release, or are subject to weekend incarceration. Jails range in size from tiny rural jails with less than a dozen cells to massive urban facilities housing thousands of inmates. In some jurisdictions, large jails operate like prisons.

With a high turnover rate and relatively short terms of incarceration, jails experience a specialized set of problems. Traditionally, jails have afforded few opportunities for any sustained offender involvement in an AOD treatment program, but this situation is beginning to change. In recent years, jails have begun incorporating programming to address AOD interventions. In some large jails with significant numbers of inmates who may remain for extended periods of time, it is necessary to provide programming similar to that provided by prisons, which includes AOD treatment. For short-term pretrial defendants, the goal of jailing is to ensure their presence at trial. However, for sentenced offenders, treatment goals can be similar to those in some prisons. For jails where there are long pretrial confinements, appropriate AOD treatment also is a concern.

A full range of AOD services can be made available in larger jails. In particular, the jail setting is in several ways an appropriate setting for detoxification programs. *Detoxification* is a structured medical or social milieu in which an individual who is dependent on alcohol and/or other drugs is monitored during withdrawal from the acute physical and psychological effects of addiction. The jail setting provides the high level of structure and the opportunity for monitoring -- which sometimes involves 24-hour physician or nurse supervision -- that are necessary for detoxification. Detoxification is an essential first step in moving clients into AOD treatment, a step which can be completed in the jail setting even for those having long pretrial confinements

or serving short sentences. In particular, detoxification and methadone programs, which address opiate addiction within the jail setting, can engage many individuals in treatment who might not otherwise seek it. Another TIP in this series, TIP 19: *Detoxification from Alcohol and Other Drugs*, describes safe regimens for detoxification in a variety of settings.

A medical unit is an essential jail component that includes outpatient care and inpatient hospitalization. Comprehensive services include health and medical programs for AOD-abusing individuals with mental illnesses and for patients with human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, or tuberculosis (TB). These services also include care for women's specialized needs. An enhanced voluntary program for HIV counseling and testing should be considered. Procedures should also be established to provide AOD treatment and other needed health-related services to inmates in protective custody or administrative segregation.

It must be noted here that it is an unfortunate reality that AOD abuse often can continue in jails. Therefore, another important component of a jail program is the monitoring of AOD use.

Prison

A *prison* is an institution in which felony offenders are confined to terms of at least 1 year after sentencing. Prisons are operated by States and by the Federal Government. Prisons are classified as minimum-, medium-, or maximum-security facilities, based on the need for internal institutional safety and perimeter security. Each inmate is classified by severity of offense or other behavior and is usually assigned to a prison with a corresponding level of security.

Prison inmates are generally sentenced to a minimum of 1 or 2 years, depending on the State's laws. In some States, such as New York, California, Florida, and Illinois, prison sentences may be shorter than 1 year. Prisons, unlike jails, do not hold pretrial detainees. Because of the longer time periods involved for most offenders in prison, prison programs can have long-term components that are not options in jail programs. Historically, prisons have existed for punishment and incapacitation. It has only been in recent decades that policies have been implemented to emphasize habilitation and rehabilitation. Since many AOD-abusing individuals are sent to prison, a full range of AOD treatment services should be available in prisons.

A number of issues relate specifically to prisons and AOD treatment:

- Comprehensive pregnancy management for AOD abusers can enable a woman to carry her baby to term while incarcerated. Foster care services may be needed, and medical services should be available for both mother and child.
- Medical treatment for prisoners with chronic and communicable diseases, including TB and HIV/AIDS, should be available in prison.
- Psychiatric treatment for prisoners with mental illnesses should be offered. Pharmacotherapy for disorders such as bipolar disorder and major depression should be incorporated into these services.
- AOD abuse treatment should extend across institutional boundaries when offenders are transferred to different correctional facilities, and to the community after release.

- Special arrangements should be made for AOD treatment and healthcare services for offenders in protective custody and administrative segregation.
- Prerelease group programs and transitional community programming should be offered to all offenders, in particular to those who have been incarcerated for long periods of time.
- Education about HIV/AIDS and its risk factors should be a critical component of prison programs.
- Relapse prevention for AOD abusers should be a part of transitional programming.

The recognition of the overwhelming AOD problems of prison inmates has led to increasing acknowledgment of the needs of this population in prisons. In many cases, this need has created a dilemma. Should an AOD abuser be sent to prison, which may offer the best treatment opportunities, or be placed in a community setting, which may offer fewer opportunities? The answer to this dilemma is not to take treatment out of prisons, but to create treatment options in the community.

Parole

Parole is a form of supervised release into the community following a term of incarceration. In most States, a parole board decides on a case-by-case basis which inmates to release from prison, when (at what point in the total sentence), and under what conditions. In the same way that a judge orders specific conditions of probation, the parole board orders specific conditions of parole. Failure to comply with the conditions can result in a motion to the board to revoke parole and return the parolee to prison. AOD abuse treatment and some of the intermediate sanctions described in [Exhibit 4-1](#) are common conditions of parole release.

Not all States have parole as part of their sentencing laws. In California, Washington, and Minnesota, for example, an offender serves the term specified by the judge at the time of sentencing, minus time off for good behavior or program credits, if those are available in the State. In that case, the offender leaves prison under mandatory release and usually has no conditions on that release.

Parolees are supervised by parole officers, sometimes called parole agents. Parolees may have prohibitions on certain activities imposed by a paroling authority. Parole officers have the same authority with parolees as probation officers do with offenders on probation. The primary goal of parole is community reintegration after release from prison. The parole officer's role has evolved from supervisor to case manager, particularly for AOD-involved offenders.

The primary goal of the parole officer is to ensure community safety. Other goals are to help offenders in the transitional process of returning to society and to assist them in making appropriate choices from available community options. The parole officer often gradually reintroduces choices that the offender will need to make to become self-sufficient and adjust to the community. Specific objectives should be individualized for each offender. Thus, parole officers must be change agents. Sanctions should be used to assist treatment and habilitation outcomes and to encourage the offender to participate in community programs.

The location of the parole department within the State governmental structure has an effect on services. Parole departments are located in different divisions of government throughout the

country. In one State, parole may be located within the corrections department and probation within the judiciary. Location translates into differences in communication, cooperation, interaction, and philosophical perspective. Location also can be related to service fragmentation and shifting departmental responsibility.

Although the parole board usually is the final arbiter, decisions involving parole should be made with input from the parole board and officers, the offender, and the treatment providers. A parole plan should be based on clear objectives so that all involved personnel know what is needed to reach the stated goals. This process also will assist parole officers in monitoring parolees and will help parolees know specifically what is expected of them.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Chapter 5 -- The AOD Abuse Treatment System [2](#)

This chapter presents an overview of the alcohol and other drug (AOD) abuse treatment system. The AOD system is complicated because Federal, State, and county sources may provide funding and may have separate oversight and accountability requirements. (There also are private treatment programs, but they are not covered in this chapter.) Treatment approaches and services presented here and used in various parts of the country incorporate a variety of settings and modalities and include detoxification; inpatient, outpatient, intensive outpatient, and residential treatment; methadone maintenance; and self-help groups. Individual, group, and family interventions are used as part of the intervention repertoire to change specific behaviors such as AOD abuse. In addition, prevention and educational interventions are used in communities across the United States with the goal of decreasing AOD abuse.

The Role of State AOD Agencies

Knowledge of the AOD abuse treatment system is needed to effectively develop intervention programs within the criminal justice system. Current treatment can be better understood in its historical context. AOD treatment emerged from the mental health system during the 1950s. Many AOD treatment professionals remained concerned with protecting the independent treatment service structure. The battle to establish independent AOD treatment services was difficult. Many in the field developed a strong sense of keeping perceived "outsiders" such as physicians and hospitals from becoming involved in treatment and related issues. Professional associations were formed; and, as Federal and State AOD treatment funding became available, State AOD treatment organizations developed. Today, in each State a single State AOD agency, led by a State AOD director, not only administers Federal block grant funds and sets treatment standards, but is also the hub for organized public programs. As criminal justice systems develop and adopt treatment programming, an understanding of the critical role State AOD agencies play in relation to publicly funded AOD programs is essential.

State AOD agencies provide technical assistance (TA) in both treatment program management and service delivery. State agencies are mandated by law to establish regulations for certifying treatment providers and licensing programs. State agencies also routinely monitor certified providers and licensed programs to ensure that high-quality services are delivered. While most States do not mandate licensure for correctional treatment programs, it is recommended that justice system treatment programs pursue State approval. States may need to develop specific licensing criteria for correctional treatment programs. Pursuing State approval for justice system programs can, at a minimum, provide the impetus to establish a working relationship with the AOD treatment community, gain recognition for the justice system program as a treatment provider, and educate State agencies as well as treatment providers about the special needs of offenders.

State licensing of justice system AOD treatment can, at a minimum, provide the impetus to establish a working relationship with the AOD treatment community, gain recognition for the justice system program as a treatment provider, and educate State agencies as well as treatment providers about the special needs of offenders.

Another valuable contribution the State AOD agency can make is linking the correctional program to licensed treatment delivery. Depending on the setting and type of program, the criminal justice agency's best approach may be to contract with established providers. State AOD agencies can guide criminal justice professionals in selecting the best match between the justice system and a treatment provider optimally suited to providing services to the offender population.

CSAT's Two-Phased Technical Assistance Program

Since 1991, the Center for Substance Abuse Treatment (CSAT) has advised State AOD agencies to consider offenders' needs when developing statewide plans and strategies for improving treatment. CSAT has been engaged in a major initiative intended to improve linkages at the State level between the substance abuse treatment system and the criminal justice system. CSAT's technical assistance project involves two phases of work with the State AOD agencies that have elected to participate in this effort. This two-phase process helps key decisionmakers in the States begin to see where their agencies and jurisdictions fit into the big picture.

In the first phase, CSAT provides a systemic assessment and organizational analysis of the State's AOD and justice agencies, looking across traditional agency boundaries and examining the overriding roles, decision points, and service responses affecting the AOD-involved offender. The assessment determines where linkages are already in place and where the State might benefit from technical assistance.

After the review process, a developmental action plan for technical assistance is presented to the State AOD director. The plan's recommendations reflect the priorities of the State director, build upon existing State initiatives, and identify leverage points in the systems where technical assistance can have maximum impact. In the second phase, technical assistance is delivered. This

TA is sometimes launched by a criminal justice roundtable at which key AOD and justice decisionmakers meet and discuss goals and plans for best using the technical assistance.

Overcoming Barriers

Open collaboration between the two systems is the approach that best serves offenders and meets the goals of AOD treatment programs. However, some barriers must be overcome before this collaboration can occur.

For example, although some community AOD programs treat nonincarcerated offenders, others may be reluctant to do so. Frequently, this barrier to open collaboration becomes apparent immediately, and sometimes it is difficult to overcome. Another barrier can result from fundamental differences between the two systems. AOD treatment providers are accustomed to working with clients who enter treatment voluntarily, often as self-referrals. Justice "clients" are not voluntary, although their level of cooperation in treatment may be high. Treatment programs may have waiting lists with no pressure to increase their capacity, while system overcrowding may make it impossible for the justice agency to control its population, despite what is known about best criminal justice practices. These basic differences can lead to considerable confusion when both systems negotiate agreements or service contracts.

Fragmentation of Services Within the AOD Treatment System

Given the fact that the AOD treatment system is still evolving, it is not surprising to find a wide array of services to meet clients' needs. No single approach to treatment works for all persons, and the complexity of the field has arisen largely in response to that truth. Effective AOD treatment is provided by individuals from a wide variety of disciplines, with diverse backgrounds and approaches, with an array of treatment strategies and modalities, and in a variety of settings. Although treatment providers all share the same goal, conflicts sometimes arise when certain groups of providers feel that the efficacy of their approach is not recognized or might be replaced by other approaches and providers. In addition, philosophical differences sometimes divide providers who focus solely on treatment of alcohol abuse and alcoholism from those who focus on drug addiction and use of illicit drugs.

CSAT has been enlarged to a two-phase initiative to improve linkages at the State level between the substance abuse treatment system and the criminal justice system. The first phase determines where linkages are already in place and where the State might benefit from technical assistance. The second phase is the delivery of technical assistance, sometimes launched by a roundtable at which key AOD and justice decisionmakers meet and discuss goals and plans.

Although conflicts have arisen, the AOD treatment field as a whole has grown more sophisticated. Treatment providers from all disciplines increasingly recognize that addiction is a biopsychosocial condition. Given the holistic nature of the disorder, no single group can address the biological, psychological, and social aspects of addiction. The field has made room for all.

The importance of addressing client needs in areas traditionally outside the realm of AOD abuse counseling is being acknowledged. Attempting to meet all of these needs can be a significant undertaking and can lead to a perception that treatment services are fragmented among a number of diverse groups with needs that go far beyond traditional counseling and support. For example, many persons who use injection drugs and share needles acquire human immunodeficiency virus (HIV) and other diseases. To obtain Federal funds, programs must fulfill requirements for providing services to injection drug users, which can further fragment the system by dividing the population to be served. In addition, providing childcare is an important factor in ensuring that some women engage successfully in treatment. Treatment programs that choose to fund childcare sometimes must divert funds from money that would have been used for direct treatment services.

However, some forms of fragmentation are lessening. In many States, the long-standing competition is ending between treatment services for those addicted to alcohol and for those addicted to illicit drugs. An increasing number of States are using terms such as chemical dependency, substance abuse, and alcohol and other drug abuse to describe combined approaches. Most of the philosophical reasons for the distinction between alcohol abuse and illicit drug use are inappropriate, but some practical and clinical factors remain.

While fragmentation has resulted from multiple changes in the AOD system, the same forces have forged flexibility and creative problem solving. Working in a rapidly changing environment takes its toll, but the treatment field on the whole is responsive to new approaches that can lead to high-quality care. As healthcare costs increase, the AOD treatment field is being recognized as a system that can effectively prevent and treat healthcare problems.

Variations Among States

Understanding the AOD treatment field and its rapid growth and development in the last decade helps explain the wide array of organizational models seen in different States. Many States have umbrella social service organizations that include the AOD treatment system. Sometimes the umbrella organization is the social service, health, or mental health agency. In this model, health, mental health services, and AOD treatment services are in the same organizational branch, but never merged. Some States have created cabinet-level departments or commissions for AOD services.

While fragmentation has resulted from multiple changes in the AOD system, the same forces have forged flexibility and creative problem solving. Working in a rapidly changing environment takes its toll, but the treatment field on the whole is responsive to new approaches that can lead to high-quality care. As healthcare costs increase, the AOD treatment field is being recognized as a system that can effectively prevent and treat healthcare problems.

When criminal justice professionals approach AOD systems, it is advisable to inquire about the stated mission and goals of the larger agency and the working relationship between AOD services and other social and health services. This information may help provide an

understanding of AOD treatment, because only a few States deliver AOD treatment services directly. In fact, most contract with certified private treatment providers or county governments.

The necessary involvement of the single State AOD agencies in treatment is generally helpful, but their involvement can also create problems by adding a layer of politics and bureaucracy to the delivery of treatment. For example, some State agencies operate their own AOD treatment programs and may want the criminal justice system to make referrals directly to them, not to community providers.

In many States, county systems play key roles in local needs assessments for prevention and treatment services. These county systems also disburse funds to service providers. Often, county-level working relationships between courts and the AOD system are more collaborative than those at the State level and can be enhanced. County government, unlike State government, often benefits from a sense of community. Cross-system efforts usually are easier and more "natural" with neighbors than they would be in the climate of strained relationships that can exist between State agencies. However, relationships on the local level can be badly strained by a history of not communicating or not working together.

Policy issues can divide AOD professional associations and, in some States, pit the associations against the State or county governments responsible for funding AOD programs. It is recommended that justice professionals ask the State AOD agency about the existence and activities of professional associations and be as inclusive as possible in initial forays with AOD providers.

Some States have a governor-level commissioner or "drug czar," usually with a discrete cabinet-level agency. The commissioner can be a high-level policy coordinator, with responsibility for bridging law enforcement, education, prevention, and treatment activities. Contacting the commissioner can be an effective starting point for justice professionals interested in linkages with treatment resources.

However, the principal police intervention is arrest, and police are trained to look primarily for probable cause that can lead to arrest. In many cases, early warning signs and symptoms of AOD abuse precede probable cause for arrest, but police officers may be precluded from engaging in prevention efforts because of their orientation, time constraints, and lack of familiarity with AOD prevention techniques.

Community AOD abuse prevention efforts should

- Be cooperative
- Be collaborative
- Be sustained
- Be integrated
- Involve multiple strategies.

Police often meet their primary obligations by identifying current and potential problems,

mediating disputes, deescalating crises, and recommending solutions. Many of these activities are remarkably similar to those used by social service providers. When the police are further informed about such topics as addiction, treatment, recovery, codependency, and dysfunctional families and become knowledgeable about local resources, their ability to provide prevention services is greatly enhanced.

In the early 1980s, a new direction in law enforcement began to emerge that has since become known as community policing. The community policing philosophy reaffirms that proactive crime prevention, not merely responding to calls for service, is the basic mission of the police. Community policing takes different forms, depending on the needs of the community in which it is applied. In general, police maintain a visible presence in neighborhoods; officers move from positions of anonymity in patrol cars to direct engagement with the community, giving police more immediate information about problems unique to the neighborhood and insight into their solutions. Police undertake activities to solve crime-producing problems, arrest law violators, maintain law and order, and resolve disputes. At the same time, community policing is anchored in the concept of shared responsibility for community safety and security. In community policing, the police and citizens are partners in establishing and maintaining safe and peaceful neighborhoods; this partnership approach improves relations between police and the public.

In some jurisdictions, community policing includes specific activities to prevent drug abuse and refer people to treatment. For example, in Portland, Oregon, the program features a landlord-training component aimed at reducing drug activity on rental property.

Criminal Justice System Treatment

As discussed in the previous chapter, the goals of the AOD treatment and criminal justice systems might at first appear to be dissimilar or even antagonistic; however, a more thorough examination reveals shared goals, with a potential for the two systems to complement each other and enhance overall effectiveness.

The benefits derived from such cooperation can flow both ways. AOD treatment for offenders helps the criminal justice system reduce recidivism and gives alternatives to incarceration, when appropriate. Treatment within prisons and jails may ameliorate inmate behavior problems. Policymakers and others are beginning to understand that neither AOD treatment nor criminal justice efforts alone are sufficient to deal effectively with AOD-involved offenders([*TIE Communique*, 1993](#)).

As discussed in [Chapter 1](#), extensive cooperative efforts have already been undertaken in the form of drug courts and other efforts to divert some substance-abusing offenders into treatment rather than into extensive, costly, and often repeated involvement with the justice system. The national crime bill passed in late 1994 allocated \$1.8 billion to drug courts. Drug courts are special courtrooms that integrate substance abuse treatment and justice system case processing under close supervision of a judge. All of these programs involve a conception of the role of the court (and of judges and lawyers) that goes well beyond the traditional narrow view of the court as simply an adjudicative institution and places at least as much emphasis on effective treatment of individuals with substance abuse problems as on the adjudication of cases. All of the programs

involve the close collaboration of courts with the treatment community and with other societal institutions in the design and ongoing operation of a program.

It is beyond the scope of this TIP to describe in detail the concepts and operations of drug courts and other forms of alternative case processing. However, other TIPs in this series, TIP 23: *Integrating Alcohol and Other Drug Abuse Treatment With Pretrial Processing of Criminal Cases and Combining Alcohol* and TIP 21: *Combining Alcohol and Other Drug Abuse Treatment with Diversion for Juveniles in the Justice System* examine the cooperation of the two systems in these areas.

As reflected in the CSAT Criminal Justice Treatment Planning Chart ([see Appendix B](#)), AOD interventions, including screening and assessment, education and prevention, and treatment, are appropriate at every stage of the justice system continuum, from arrest through parole and mandatory release. Linkages at every level will further ensure that treatment follows the offender through the justice system.

Approaching the AOD System

A careful analysis of the AOD system is needed to prepare for joint program strategies. Those with experience in the treatment-justice linkage are aware of problematic issues. Fortunately, a variety of mutually beneficial public policy agendas exist that can be used to facilitate collaboration between justice and treatment. The effort to control AOD abuse can bring the justice and AOD systems in closer proximity to each other. While many view the end of one system's responsibility as the beginning of the other's, professionals in both systems now have a better understanding of the repetitive, circular nature of the interactions among the justice system, the AOD treatment system, and the community.

Incarcerated AOD-Involved Offenders

AOD education and treatment differ depending on whether the targeted population is confined to a jail or a prison. While prison terms are generally measured in years, jail sentences are generally measured in days and months. Short stays, varying lengths of stay, and frequent disruptions such as court appearances, combined with overcrowding and understaffing, can make some jails less than ideal settings for effective AOD treatment. However, as discussed above, with adequate resources and careful linkage planning, effective treatment can be provided, or at least begun, in jails. In particular, given the characteristics of jails, flexible programming from community providers is critical. Some of the most innovative and creative AOD treatment approaches are taking place in jails. These range from educational and outpatient treatment services to entire jail facilities committed to treatment.

Regional collaborations among some jail jurisdictions have led to coordinated programming, including work-release programs, interventions related to driving while intoxicated (DWI), drug abuse education, and special treatment services. Jails also provide opportunities to identify lower risk populations that can be treated in separate, lower security facilities.

AOD treatment providers assisting incarcerated populations often must work in difficult

situations with constraints on space, resources, and offender movement. If possible, inmates receiving AOD treatment should be segregated from the rest of the jail or prison population, although the lack of resources makes this arrangement impractical in many institutions. Segregation of inmates receiving treatment would permit the establishment of a supportive social milieu within the institution. The social milieu, in which individuals in treatment participate in a structured program and form supportive bonds with others in treatment and with treatment staff, has long been a critical aspect of recovery from AOD abuse and dependence.

The benefits derived from cooperation between the criminal justice system and AOD treatment system can flow both ways. AOD treatment for offenders helps the criminal justice system reduce recidivism and gives alternatives to incarceration, when appropriate. Treatment within prisons and jails may ameliorate inmate behavior problems. Neither AOD treatment nor criminal justice efforts alone are sufficient to deal effectively with AOD-involved offenders.

Referrals

Referral to appropriate AOD treatment, whether it is in the community or in a correctional facility, is a critical element of cohesive and continuing service for the AOD-involved offender. To make an effective referral, criminal justice and AOD treatment personnel must know what resources are available to address not only the offender's AOD treatment needs, but also needs in the areas of mental health, medical care, and vocational and social services. In addition to knowing available resources, staff also should have a general understanding of how different programs operate and how staff can access services. For example, staff should know specifically which types of programs will accept referrals and their hours of operation, costs, rules, and expectations. Staff also should be able to explain how a program works and what an offender can expect from it. Similarly, staff should be able to assess a program's ability to meet the offender's treatment needs and whether the offender can benefit appropriately from each treatment approach. The most effective referral procedures are developed when personal contact and relationships are involved. For this reason, criminal justice and AOD treatment staff should make active attempts to establish personal relationships and linkages.

Effective referrals involve thorough knowledge of the available resources, including

- Knowing how the resources operate
- Understanding their rules, hours, costs, and expectations
- Knowing that each referral made is a good match
- Developing personal relationships with resource providers.

Referral Feedback

Rapid and open feedback helps make the AOD treatment and criminal justice systems function more effectively. Clear procedures are a foundation for timely feedback and rapid action and for establishing ongoing trust in the partnership of the systems.

As described in more detail in [Chapter 8](#), Federal and State regulations protect the confidentiality of individuals who are receiving AOD assessment, referral, or treatment services. Special procedures must be established for sharing information about offenders in treatment. Some criminal justice personnel believe that confidentiality requirements impede feedback. However, routine use of consent forms can help overcome the perception of confidentiality as an obstacle. Unfortunately, feedback between the systems about referrals can be disjointed or nonexistent. Thus, in many jurisdictions, formal arrangements and coordination are necessary to channel appropriate information to relevant staff.

Pretreatment for Incarcerated Offenders

Pretreatment is the process of educating, preparing, and motivating individuals for treatment when appropriate programs are not immediately available. The pretreatment process is intended to prepare offenders for treatment by

- Providing education about recovery
- Increasing self-awareness regarding abuse and addiction and their effects on individuals and their families
- Providing understanding of the need for treatment
- Increasing awareness about solutions and resources
- Generating treatment motivation.

Although pretreatment is appropriate at every stage of the justice system for both nonincarcerated and incarcerated individuals, it is particularly useful in correctional facilities when there is a waiting list for community-based programs or limited capacity for institutional treatment. In institutions where no treatment is available, pretreatment helps individuals make the transition from being inmates to being participants in AOD treatment programs when they become available, and it helps to demystify the treatment and recovery process.

Pretreatment efforts can include education about the drugs of abuse and their effects, the effectiveness of treatment, and the benefits of living a drug- and alcohol-free life. In jails, where some offenders have very short stays, flexibility of pretreatment programming is essential. Based on needs assessment of their jail populations, personnel can decide which pretreatment components are critical to engaging individuals in treatment and divide pretreatment curricula into flexible units.

A treatment plan developed at this stage can address vocational, familial, and social issues that will help support treatment goals, minimize the risk of relapse, and decrease the risk of criminal behavior.

Transition From Institution to Community

It is important to recognize the need for offenders to make a smooth transition into the community, a process that involves identifying and addressing special needs before the offender's release from the institution. For those who have served a full term and for whom there are no conditions of release, incentives should be given to participate in treatment after

incarceration. For example, increased contacts with and support from AOD counselors in the weeks prior to release may provide some offenders with the necessary incentive. Separate support groups for offenders who have received treatment while incarcerated and who are anticipating release can provide valuable peer support for remaining AOD free. These groups can invite treatment "alumni" who have successfully made the transition to the community. Meetings with offenders' families when appropriate prior to release can also enlist additional support. Such efforts can be effective for all offenders anticipating release, including those who will be paroled and for whom continuing treatment will be a condition of release.

Treatment plans should be

- Biopsychosocial in nature
- Multidisciplinary in delivery
- Comprehensive in scope
- Driven by ongoing assessments
- Closely monitored.

At the end of the period of incarceration, recommendations about community-based treatment programs should be incorporated into parole plans. The case manager or AOD treatment coordinator should be involved in establishing the conditions of parole when appropriate. Sanctions regarding the offender's performance while in treatment also should be discussed in detail with the offender, appropriate community treatment program staff, and the parole officer.

The initial hours and days following an offender's release are critical with respect to relapse prevention and recidivism. There is a high rate of relapse shortly after release. Careful monitoring, especially over the first few days, is imperative. The first 24 hours after release can be especially critical, and there must be a system in place to ensure that an individual released from incarceration gets into treatment or a support group quickly. In many systems, 72 hours can elapse between the time offenders are released and the time they are required to see their parole officers. This time period should be shorter for those who have received AOD treatment services within the correctional system so that treatment goals are reinforced on a continued basis.

It is often preferable for the parole officer to accompany the offender to the treatment program after release. Because accompanying the offender raises issues of confidentiality, an effective parole officer will obtain a signed consent form from the offender before release, ensuring that he or she can provide this support in the initial period after release.

Ideally, a treatment slot should be identified and selected for use when an offender returns to the community. If a treatment slot is unavailable, temporary drug-free housing should be provided. Although self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Rational Recovery are not treatment, when a treatment slot is not available, these programs can often provide the structure to support the offender in the community until a slot becomes available. Representatives of local treatment programs, as well as self-help representatives, can be invited to the institution so that offenders have some contact and familiarity with these programs prior to release.

In their role of protection of the community, parole officers often devote much of their attention to offenders with the lowest prospects of success. They should not overlook offenders who have made progress in treatment and who have high potential for success if the transition to the community has been carefully planned and implemented and if ongoing supervision and support are provided. For all parolees, no matter how responsive they have been to treatment, control and treatment effectiveness go hand in hand.

Offenders with previous AOD abuse histories should be closely monitored on a daily basis for the first 30 days after release. Monitoring should include random urine testing and breath analysis. During the parole period, monitoring should be intensive. As treatment progress is made, monitoring can be tapered. Electronic monitoring can be arranged for special groups of offenders so their activities are known to corrections officials. This strategy responds to the security concerns of the criminal justice system while allowing offenders to participate in treatment programs.

It is important that treatment programs provide the criminal justice system and the offender with specific plans that describe the frequency and duration of treatment contacts and the consequences of noncompliance. Immediate and decisive action should be taken when offenders fail to show up for treatment or follow their treatment plan. The treatment program should provide feedback to the correctional system in such cases, and appropriate sanctions should be applied.

The first 24 hours after release can be especially critical, and there must be a system in place to ensure that an individual released from incarceration gets into a treatment program.

Treatment agencies must be able to demonstrate that they are providing an appropriate level and intensity of treatment for each person they serve. The criteria used to determine placement, placement changes, and discharge, should be used system wide and should be based on the severity of AOD problems, not the offense. These criteria should be acceptable to criminal justice administrators.

Treatment Components

AOD addiction is a chronic relapsing disorder that is influenced by numerous interacting biological, psychological, and social factors. To provide AOD treatment that addresses these biopsychosocial aspects of addiction, a full range of services should be available to the offender. These can include

- Evaluation and assessments -- medical, psychiatric, and addiction
- Detoxification
- Medical assessment, pregnancy tests, and treatment for HIV disease and AIDS, other sexually transmitted diseases, and TB
- Hospitalization
- Treatment planning -- medical, psychiatric, and addiction
- Counseling -- group, individual, and/or family

- Residential treatment
- AOD treatment education: didactic lectures, interactive groups, videos, reading assignments, and journal-writing assignments
- Relapse prevention services
- Crisis intervention
- Drug testing and monitoring
- Self-help education and support
- HIV disease and AIDS education, testing, and counseling
- Comprehensive pregnancy management: prenatal care, parenting classes, and/or childbirth classes
- Mental health services -- medications when indicated
- Social and other support services for the offender and family members
- Vocational and educational training
- AOD treatment services for family members and significant others
- Family services not related to AOD treatment
- Acupuncture for short-term control of AOD craving and other nontraditional adjuncts
- Services for special populations: people who are violent offenders, incest survivors and incest perpetrators, survivors of physical and sexual abuse, and individuals with coexisting AOD and psychiatric disorders.

In addition, a variety of adjunct services may be needed to address sexual abuse, child abuse, domestic violence, victimization, guilt and remorse, and family issues. These issues can be addressed on an individualized basis with case management and coordination.

CSAT has developed a Model for Comprehensive Alcohol and Other Drug Abuse Treatment ([Exhibit 5-1](#)). Although it is not designed specifically for offender populations, it is included here to provide readers with an overview of the multiple services that have been shown to improve the effectiveness of AOD treatment.

Screening and Assessment

A detailed discussion of AOD screening and assessment, which are fundamental first steps in identifying persons with AOD problems, is beyond the scope of this TIP. A companion TIP in this series, *TIP 7: Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*, specifically addresses these processes. It describes a variety of screening tools and assessment instruments commonly in use, specifically for offender populations. Many of these are reprinted in full in Appendix C of that TIP. Particularly useful assessment instruments that are included are the *Offender Profile Index*, which is used to determine the appropriate type of AOD abuse treatment for the offender (for example, long-term residential, intensive outpatient, or regular outpatient); the *Addiction Severity Index* (ASI), which is probably the most widely used standardized diagnostic instrument in the field; and the *AIDS Initial Assessment Jail Supplement*, which gathers information about HIV risk factors. The following discussion summarizes many of the points discussed more fully in that TIP. Screening and assessment are important procedures that are used to identify and describe an individual's AOD abuse problems. However, screening and assessment are distinct and are used differently. *Screening* is an initial process that identifies individuals who are likely to have AOD problems and indicates which individuals need AOD assessment. Screening generally includes the use of

urine toxicology tests, which are laboratory methods of detecting the presence of drugs. Blood tests are often used to determine the level of alcohol and to provide an indicator of intoxication. Because laboratory tests indicate only recent ingestion of a substance, brief screening questionnaires are frequently used to supplement laboratory results. Questions about the amount and frequency of AOD use and patterns of use have been found to be very effective in identifying persons with AOD disorders. Problems related to AOD use, such as decreased ability to function at home or at work, are also indicative of AOD disorders.

An AOD screening should be completed for all offenders entering the criminal justice system. Screening in jails can be conducted during pretrial release interviews. When offenders score positively on an AOD screening, they should receive a biopsychosocial assessment by an addiction professional. The assessment should then be combined with a corrections assessment that addresses other issues such as the offender's security needs and risk to the community. Professionals in both systems should exchange information and assessment results to create a sound basis for case management and to develop a holistic approach to decisionmaking.

An *AOD assessment* is an interview that helps determine the extent of an individual's problem with alcohol and other drugs and the appropriate level of treatment. For example, the assessment may find that an individual is addicted to cocaine as well as alcohol. The assessment also identifies problems related to AOD abuse in an individual's life. Assessments should be biopsychosocial in nature and should address medical, psychiatric, psychological, emotional, social, familial, nutritional, legal, and vocational areas to determine the levels of treatment intervention and services that will be needed.

While an AOD screening is generally a one-time event, an AOD assessment should be approached as an ongoing process. Assessment is repeated throughout treatment and throughout the offender's involvement in the criminal justice system. Changes in the offender's severity of addiction and in problems related to addiction, as well as new life problems and crises, require modifications in the treatment plan.

Treatment Planning

Based on the results of the assessment, a treatment plan is developed that describes concrete goals and objectives to help the offender correct problems identified in the assessment. The treatment plan, revised periodically based on continuing assessment, should follow the offender through the criminal justice system for continuity of care and treatment planning.

In making decisions about appropriate treatment, *patient-treatment matching* is an important concept. In patient-treatment matching, every effort is made at each stage of treatment to identify a specific individual's needs, both for AOD treatment services and other services and to secure the appropriate services to match these needs. This approach has been found to increase retention in treatment and improve treatment outcomes. The evolution of this concept in the AOD treatment field reflects the growing understanding of the diversity of patient populations and needs. It also reflects the pressures on the treatment field, as on all areas of healthcare, to reduce costs by eliminating unnecessary and inappropriate treatment.

Another TIP in this series, TIP 20: *Matching Treatment to Patient Needs in Opioid Substitution Therapy*, includes discussions of key issues in patient-treatment matching, addressing, in particular, the importance of ongoing assessment.

Even if treatment or services for special needs cannot be provided or is provided only partially, treatment options and resources should be identified and contacted. For this reason, active liaisons with community treatment and social service agencies should be developed. Treatment should take into consideration a broad range of issues, including the crimes for which the offender was sentenced, medical concerns including possible HIV infection, mental health problems, and issues related to assault by other offenders. Staff from both systems can then select from an approved "menu" of various treatment components.

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The evolution of the concept of patient-treatment matching in the AOD treatment field reflects the growing understanding of the diversity of patient populations and needs. It also reflects the pressures on the treatment field, as on all areas of healthcare, to reduce costs by eliminating unnecessary and inappropriate treatment.

The biopsychosocial multidisciplinary approach proposed here, and described more fully in the TIP *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*, will provide data to make informed decisions in the best interests of the offender and the community. Planning for community reentry should begin when offenders first enter the criminal justice system, and conducting assessments early in the process can facilitate that planning.

Relapse Prevention

Relapse, or resumption of AOD use, should be understood as a characteristic of addiction that often cannot be avoided. Individuals who become addicted to alcohol and other drugs generally do so in an environment that encourages and supports AOD use. Many use AODs to cope with emotions, moods, and negative or traumatic life events and stressors. Many environmental factors, including persons, places, and times of day, are associated strongly with AOD use. All of these factors can trigger strong desires to resume AOD use.

Relapse prevention is a strategy to train AOD abusers to identify the stressors and triggers in their daily lives that may lead them back to AOD abuse and to train them to cope more effectively to overcome obstacles to recovery. In linkages between the treatment and criminal justice systems, educating court personnel, especially judges and other persons in the justice

system about the dynamics of relapse is crucial.

CSAT has developed a Technical Assistance Publication *Relapse Prevention and the Substance-Abusing Criminal Offender* that provides an overview of the recovery process and describes approaches for preventing relapse, as well as specific relapse prevention programs in various States.

Relapse rates are high in offender populations. Relapse prevention is critical and should be part of each AOD-involved offender's treatment plan. Relapse prevention skills and activities should continue throughout the treatment process and be a particular focus for incarcerated offenders prior to release. Personal relapse plans should be developed for all parolees. The plans should include substantive input from offenders, with the understanding that after release they will be involved in making decisions about their own lives.

When relapse occurs, as it does for many in recovery, response to it is a critical element of treatment. Relapse should not be viewed as failed treatment or evidence of personal failure. Often, if properly handled, relapse can lead to increased motivation for recovery, strengthening an individual's knowledge of his or her limitations, the dangers inherent in stressors and triggers, and the individual's awareness of what he or she might lose by leaving the treatment process.

When an offender at any stage of the justice continuum and at any stage of treatment experiences a relapse, it is crucial to assess its seriousness and determine what interventions are indicated. One positive urine test or one drink after long abstinence should not be viewed as failure. Relapse should be seen as a signal noting the need for increased treatment and closer monitoring. However, because resumption of AOD abuse may lead to resumption of criminal activity, addressing relapse raises special issues. The key to renewed intervention is graduated sanctions, specified in an established treatment plan. It is essential that personnel from each system agree on the range of responses to relapse and the times that certain responses are appropriate. Many integrated systems have developed agreements in which the treatment program responds to issues of treatment noncompliance, such as relapse, and the criminal justice system responds to noncompliance with other conditions of probation or release.

Relapses must have consequences for the individual in the treatment, particularly repeated relapses. Decisions on consequences must be case management decisions based on the danger to the community and treatment progress of the offender. Sanction possibilities for relapse include

- House arrest
- Electronic monitoring
- Day treatment
- Brief jail stays.

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awareness of what he or she might lose by leaving the treatment process.

Drug Testing and Monitoring

Drug testing generally refers to the testing of bodily fluids to determine if drugs are present. Urine is the most frequently tested bodily fluid, but blood can also be tested. Testing for the presence of alcohol is usually done on breath. In addition to providing information about the presence of illicit drugs and alcohol, testing can also provide information about medications prescribed for AOD abuse, such as disulfiram (Antabuse) for alcohol abuse and naltrexone (Revia) for heroin use (and now approved to treat craving for alcohol ([O'Malley et al., 1992](#); [Volpicelli et al., 1992](#)), and medications prescribed for psychiatric problems. In addition to testing urine, breath, blood, and, in some cases, hair can be tested.

Drug testing is a vital part of AOD abuse treatment and provides a tool for determining an individual's progress in treatment and for making decisions about changes in the treatment plan. AOD abuse counselors encourage their clients to view drug testing from this perspective -- not as a punitive measure or as a way to control the individual, but as a tool that allows the counselor and client to better achieve treatment goals. In the criminal justice setting, drug testing is used for monitoring offenders' behaviors and ensuring that they comply with conditions set by the courts. Urine drug testing is an area where the differing goals of the two systems are highlighted.

Drug testing should be both a supervisory device and a therapeutic tool. For some offenders, urine testing is an important way to prove objectively to themselves and others that they are making progress. For others, urine testing can be an external source of motivation that helps them achieve abstinence. Drug testing should start at the beginning of the criminal justice process and continue from pretrial to arraignment and throughout the offender's involvement with the justice system, including parole and probation. It can be used in the context of progressive sanctions. Because drugs are available in jails and prisons, urine drug tests should also be used in those settings. Treatment programs that implement urine drug testing for incarcerated offenders will establish credibility with criminal justice officials. Testing should be done on a frequent and unscheduled basis. High-risk clients with previous recidivism and relapse experiences require strict monitoring programs to ensure treatment compliance. The sanctions that will be used in response to positive drug test results should be clearly specified.

Self-Help Groups

Self-help groups are frequently a crucial component of recovery for individuals in AOD treatment and can be especially important in providing support to recovering offenders. Self-help groups provide peer support and confrontation, and they serve as therapeutic bridges from incarceration to the community. They also help during crises and with personal growth. The best known self-help groups are AA and NA. However, there are other self-help groups that may be appropriate, depending on the offender's beliefs, needs, and interests. These include Survivors of Incest Anonymous (SIA), Rational Recovery, Secular Organizations for Sobriety (SOS), church groups, and feminist and veteran support groups. However, these groups are not a form of treatment, and attendance at meetings should not be used as a sanction.

Self-help groups offer

- Support for AOD treatment and recovery
- Peer support
- Healthy peer confrontation
- Therapeutic bridges between the criminal justice system and the community
- Crisis prevention and management
- Personal growth.

Case Management

Case management is the process of linking individuals in the treatment system with needed services in addition to AOD treatment, particularly when services are located at different sites and are provided by a variety of agencies. Supplementary services that can be provided include medical, dental, and mental healthcare; childcare and assistance in maintaining custody; housing; educational and vocational training; legal aid; and assistance in obtaining entitlements such as Medicaid and public assistance. Case management originated in the social work profession and has become standard practice in the social services and mental health fields. It is increasingly used in the AOD abuse treatment system to improve treatment effectiveness by ensuring that clients receive supports and services that enable them to continue in treatment and make the best use of treatment and other services.

In the treatment of offenders, case management creates a bridge between the treatment system and the criminal justice system and provides a way to coordinate a mutually reinforcing relationship. The case management process helps ensure that offenders meet both criminal justice and treatment system requirements by focusing on the treatment plan and the goals agreed upon. Case management creates a network of community and private agencies, criminal justice programs, and treatment programs and supports to fill service gaps. Within the criminal justice system, case management also ensures continuity in the transitions from arrest to pretrial or from incarceration to parole.

The case management function ideally starts at pretrial and continues throughout the treatment process. Policies and operations should be particularly focused on providing coordinated services during transitions between stages of the justice system. Parameters for accountability between the two systems should be clearly defined and should ensure proper and timely reporting to both systems.

Critical case management issues include identifying those who have a specific responsibility for the offender and those who make treatment decisions. Written agreement must be reached about the roles of involved agencies. Cross-training and memorandums of agreement between the AOD treatment program and the criminal justice system should be signed.

Selected case management approaches include

- **Case management provided by the justice system.** In this model, justice system case managers

are assigned caseloads at specific stages of the system, such as probation or parole. An advantage of this model is ownership by the criminal justice system of the case management process. Justice system officials are invested in the process because their own staff are implementing it and reporting back to them. A major disadvantage is that this process can be expensive.

- **Case management provided by a treatment agency.** One advantage of this model is that the case manager has a thorough understanding of the AOD treatment process. The model is community based. The disadvantages include the expense and the possibilities that the case manager may not be familiar with the criminal justice system or that the AOD treatment agencies may not have the resources for effective case management.
- **Case management provided by an agency separate from the treatment and justice systems.** To reduce costs, this model could employ a case management coordinator, with or without a caseload, to conduct intake interviews and supervise paraprofessional staff. The disadvantages of this approach include the addition of another agency to the collaboration and the expense.
- **Case management provided by a coordinator from the justice system who provides consulting services and technical assistance to support existing criminal justice case management.** One advantage of this model is system ownership. A coordinator, with or without a caseload, oversees the work of a paraprofessional staff. The coordinator can move the criminal justice system toward a greater awareness of treatment issues by providing technical assistance that demonstrates service coordination.
- **Case management provided by multidisciplinary groups in the criminal justice system for offender management.** This type of group may meet regularly and during crises. This model is the most inexpensive. However, it is the most difficult to successfully operate because no one is assigned overall responsibility for the offender.

Treatment Types and Modalities

Detoxification

Detoxification is the term used to describe withdrawal from alcohol, illicit drugs, or prescription medications that have been abused or misused. Detoxification, as the word implies, entails a clearing of "toxins" from the body. The most immediate purpose is to safely alleviate the short-term symptoms of withdrawal from chemical dependence, including physical discomfort.

Detoxification may occur in either an inpatient or an outpatient setting. It involves several procedures for therapeutically supervised withdrawal and abstinence over a short term (usually 5 to 7 days but sometimes up to 21 days), often using pharmacologic treatments to reduce patient discomfort and reduce medical complications such as seizures. It is a first step for many patients who will enter treatment, but it is not synonymous with comprehensive, ongoing treatment. The detoxification process entails more than the removal of alcohol and other drugs from the body; it includes a period of psychological readjustment that prepares the individual to enter ongoing treatment.

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prepares the individual to enter ongoing treatment.

Withdrawal from certain drugs such as sedative-hypnotics, alcohol, benzodiazepines, and barbiturates can include life-threatening seizures. Thus, it is recommended that medical detoxification be provided for these classes of drugs. Another TIP in this series, TIP 19: *Detoxification From Alcohol and Other Drugs*, describes clinical detoxification protocols for a variety of substances.

Within the criminal justice setting, there is a broad range of models, from intensive medical management in an inpatient setting to medication-free detoxification in a community-based outpatient setting. Acupuncture is increasingly used as a medication-free approach to relieving some of the discomfort of withdrawal. While many institutions do not provide pharmacologic assistance, others provide some medical management, such as dispensing medications that minimize some of the acute withdrawal symptoms.

Offenders should be educated about the withdrawal process and the type of detoxification they will receive. During withdrawal, people frequently become worried that the symptoms they are experiencing will last for prolonged periods. When educated about the expected course of their symptoms, offenders can deal more easily with withdrawal. Similarly, when offenders, AOD clinicians, and criminal justice staff all share an understanding of withdrawal, it is less likely that staff will misinterpret related behavior as purely manipulative.

Few jails have formal detoxification programs. When an offender is arrested and booked, he or she is screened for medical or other conditions that may need immediate attention. Intoxicated offenders are often held in medical services units under observation until the AOD effects diminish. If they need further intervention to treat withdrawal symptoms, they are transferred to the jail medical clinic or to a hospital, if necessary.

From an AOD treatment provider perspective, this situation raises several concerns. Many would characterize this as a "drunk tank" approach to detoxification. Jails are not certified to perform detoxification, and corrections personnel are not adequately trained. Further, detoxification is generally regarded as the first step into treatment, and how it is handled has a significant effect on treatment engagement and outcome. A more help-oriented model of detoxification is needed in a jail setting, a model that would pave the way for ongoing treatment while recognizing the importance of detaining violent or otherwise harmful individuals who threaten public safety.

Inpatient Treatment

The most intense levels of treatment are medically managed and medically monitored intensive inpatient hospitalization. At these levels of care, offenders are hospitalized. They can receive treatment for detoxification, medical problems associated with or unrelated to addiction, and psychiatric disorders, although not all individuals need these services. Participants also engage in psychosocial treatment for addiction that can include education, group therapy, and self-help.

Medically monitored intensive inpatient treatment usually provides 24-hour nursing care under

the direction of a physician. In contrast, medically managed intensive inpatient treatment has 24-hour medical care in an acute medical-care setting. This approach is valuable for patients who have severe withdrawal or biomedical, emotional, or behavioral problems that require primary medical treatment.

Residential Treatment

Residential treatment incorporates several different models, approaches, and philosophies for the treatment of AOD disorders that involve cooperative living for people receiving treatment. Specific residential treatment approaches with various lengths of stay have been designed for offenders. Residential treatment programs vary with regard to intensity of treatment. Some programs provide treatment services 8 or more hours a day, 5 to 7 days a week, with clinical staff available both days and evenings. Other residential programs are recovery homes for employed residents, with evening and weekend AOD treatment and limited onsite staff supervision.

The physical environments of residential treatment programs vary greatly. The environments include hospitals, facilities on hospital grounds, institutional housing, multiroom houses, sections of apartment complexes, and dormitory-like structures. Residential treatment programs also vary in philosophical approach. Some therapeutic communities provide psychological treatment focusing on a global change in lifestyle and rehabilitation. Other residential programs are biopsychosocial but focus more on treatment and less on vocational counseling, work therapy, and social services. Other residential treatment programs have several self-help group meetings throughout the week, while others encourage or require attendance at community group meetings.

Residential treatment programs may be targeted to special populations. They may be designed for adult or younger offenders, males, females, pregnant women, people who are employed or unemployed, or individuals with psychiatric disorders. Most residential treatment models designed for offenders use a group approach to treatment, recovery, and rehabilitation. The purpose of group-centered residential treatment is to create an environment that duplicates certain aspects of a family. For example, residents in many of these programs must cooperate and collaborate on daily projects such as household chores, laundry, and meal preparation. This approach is therapeutic because it prompts problem solving, communication, goal setting, and combined efforts to accomplish single goals.

All residential treatment should be followed by continued care in an outpatient setting. It is important that residential treatment become part of continuing treatment, as outlined in the assessment and treatment plan. The Federal Corrections Institute in Lexington, Kentucky, has established a treatment program, Atwood Hall, that is an example of an intensive AOD residential treatment program. It includes 12 months of more than 10 hours of daily treatment and 6 months of supervised aftercare. In philosophy, it is a self-help-oriented program that uses group therapy, individual counseling, and large groups to deal with issues of denial, recovery, relapse prevention, and cognitive coping skills.

Therapeutic Communities

Therapeutic communities (TCs) are residential programs that allow individuals to phase into independent living. Several types of drug-free residential programs have been developed to treat a wide spectrum of AOD abusers. The traditional TC model involves a long stay, usually ranging from 15 to 24 months, although many modified TCs are structured for 6 to 18 months. The TC model focuses on global rehabilitation in which AOD treatment is incorporated.

The TC approach views AOD abuse and other problems as reflections of chronic deficits in social, educational, vocational, familial, economic, and personality development. Thus, the principal aim of the TC is global life-style change, including abstinence from AODs, elimination of antisocial behavior, enhanced education, constructive employment, and development of prosocial attitudes and values.

The TC incorporates comprehensive rehabilitation services in a single setting. Services include vocational counseling; work, group, and individual therapy; recreation; education; and medical, family, legal, and social services. The primary TC "therapist" is the TC community itself, consisting of peers and staff who model successful personal change. Staff members are usually former AOD abusers who were treated in TC programs and who serve as guides in the recovery process.

The foundation of the TC approach includes structure, mutual self-help, work as education and therapy, peers as role models, and staff as rational authorities. The TC structure encourages offenders to arrive as patients and leave as staff. Job functions are hierarchical and based on seniority, individual progress, and productivity. Work serves to teach offenders how to negotiate social and occupational worlds. Peers and staff encourage self-motivation, commitment to work, positive regard for authority, and an optimistic outlook.

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The role of discipline and sanctions within TCs can be particularly valuable for offenders. The explicit purpose of discipline and sanctions is to ensure health and safety. Surveillance can be potent in TCs. One of the most comprehensive forms of surveillance is the "house run," which involves staff and senior residents walking through the facility to examine the overall condition. Examining the facility permits early problem detection. It also provides observable, physical indicators of the use of self-management skills as well as indicators of the attitudes, emotional status, and awareness of residents and staff.

Outpatient Treatment

Like residential treatment programs, *outpatient* AOD treatment incorporates several approaches, models, settings, and philosophies. The most obvious difference among outpatient treatment programs is level of care. Outpatient treatment ranges from traditional outpatient services to intensive outpatient treatment (IOT) programs. *Traditional outpatient treatment* is used here to describe treatment provided by clinical addiction professionals in organized clinical settings. This treatment occurs in regularly scheduled sessions, with usually fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with self-help activities. Because traditional outpatient treatment involves a limited number of sessions per week, it has been described as nonintensive treatment.

In contrast, *intensive outpatient treatment* consists of regularly scheduled and structured sessions with a minimum of 9 treatment hours per week. Examples or models include day or evening programs in which clients attend a full spectrum of treatment programming while living at home or in a special residence. Another TIP in this series, TIP 8: *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, describes one approach to this level of care.

Variants of traditional outpatient treatment and intensive outpatient treatment can be adapted to meet the needs of incarcerated and nonincarcerated offenders within the justice system. Within the AOD treatment continuum, intensity decreases over time if an individual meets treatment goals. For example, offenders receiving AOD treatment may initially be placed in inpatient settings during withdrawal, followed by intensive outpatient treatment and continuing care. In contrast, outpatient treatment provided in correctional institutions is often less intense than that provided by AOD programs in community settings. Thus, offenders may receive more intense treatment after leaving a correctional setting, even though they continue to receive outpatient treatment.

Outpatient services can incorporate treatment topics and use group processes consistent with those used during an offender's institutional stay. Treatment or education begun within the institution also can provide a springboard for community outpatient care. Outpatient treatment can be provided to many more offenders for the same level of funding as residential treatment. Thus, outpatient treatment is a cost-effective option for some offenders.

"Boot Camp" Programs

In response to mandatory drug sentencing, there is a trend in many jurisdictions to develop "boot camp" or "shock incarceration" programs, mostly for young drug offenders. There are currently 47 such camps operating in 27 States and two in the Federal Bureau of Prisons. New York has the largest program, accounting for 30 percent of all inmates in boot camps. The approach incorporates a highly regimented, military-style schedule combined with confrontation, discipline, and behavior modification, in the belief that discipline and humiliation will shock young criminals into shape. The New York State Department of Correctional Services has estimated that the roughly 9,000 boot camp graduates to date have saved the State an estimated \$305 million in custody and capital costs ([Yen, 1994](#)).

However, there is some question as to whether these programs reduce recidivism among young criminals. A recent eight-State study funded by the National Institute of Justice ([MacKenzie and Souryal, 1994](#)) concluded that recidivism rates of "shock graduates" are comparable to those of the general prison population. However, in New York the State Division of Parole has found a statistically significant reduction in recidivism within the first 2 years after release from the camps. After 4 years out, however, the recidivism rate of boot camp graduates was almost identical to the rate of regular parolees. The New York study found that high-quality AOD abuse treatment programming played a significant role in the improved recidivism rates in the first 2 years.

Opioid Substitution Therapy

Methadone and, more recently, LAAM (levo-alpha-acetyl-methadol) are used as opioid substitutes in the treatment of opiate users. These substitutes prevent withdrawal and block the effects of opiates, discouraging continued use of illicit drugs. With methadone, the individual is required to attend the methadone clinic once every day to ingest the methadone dose. LAAM is a longer acting (72 hours) opioid substitute, and clinic attendance is reduced accordingly when it is administered.

Three TIPs in this series, TIP 1: *State Methadone Treatment Guidelines*, TIP 20: *Matching Treatment to Patient Needs in Opioid Substitution Therapy*, and TIP 22: *LAAM in the Treatment of Opiate Addiction*, provide detailed descriptions of this treatment modality and related issues. A controversial issue that is raised in most discussions of methadone is the argument by some that methadone treatment "substitutes one drug for another"; many individuals remain on methadone indefinitely. Some people both inside and outside the treatment field believe treatment should result in a drug-free, or abstinent, state. In fact, in some areas, individuals receiving methadone are considered drug users and cannot enter drug-free treatment or support groups.

Most research, including several very large studies, has shown that participation in methadone treatment is associated with a reduction in illicit opioid use, a reduction in criminal activity, increased employment, and improvement in psychological status ([California Department of Alcohol and Drug Programs, 1994](#); [Hubbard et al., 1989](#); [Senay, 1989](#)). In addition, those involved in methadone maintenance treatment receive social, vocational, legal, and educational support services. Methadone maintenance also is an important approach used to reduce the incidence of needle sharing, and it helps reduce needle-spread diseases such as hepatitis and HIV. For many people, methadone maintenance is an opportunity to begin psychosocial stabilization and normalization, an introduction to self-help, and a pathway to abstinence and sobriety.

Offenders must be evaluated both medically and psychologically to determine if methadone maintenance is appropriate. These decisions must be individualized and based on medical history, psychological profile, HIV serostatus, and length of incarceration. Since the early 1970s, methadone maintenance has been recommended as a treatment for opiate-dependent pregnant women. For these women, methadone maintenance prevents erratic maternal opioid drug levels and protects the fetus from repeated episodes of withdrawal. Methadone treatment also can

reduce the incidence of obstetrical and fetal complications, *in utero* growth retardation, and neonatal morbidity and mortality. Maternal nutrition usually is improved and exposure to HIV disease through ongoing needle use can be minimized.

Criminal Justice Sanctions And Treatment Incentives

After a person is involved with the criminal justice and treatment systems, successful treatment outcomes depend in part on the level of collaboration and cooperation between the two systems. One aspect of this collaboration involves sanctions and incentives. The criminal justice system should have a hierarchy of sanctions available to use in conjunction with treatment incentives and rewards to improve AOD treatment outcomes. Decisions regarding the types and structure of sanctions can be developed jointly by the AOD treatment and criminal justice systems. These sanctions should be applied consistently for positive drug tests, no-shows for treatment, prohibited behavior, or broken program rules. Sanctions should be swift and certain and can include increased frequency of urinalysis, short jail stays, and increased reporting to supervising criminal justice system staff. Another TIP in this series, TIP 12: *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, gives a detailed overview of sanctions and their effective use.

Both systems can benefit from effectively applied sanctions. For treatment providers, sanctions coupled with rewards help reinforce treatment goals. The criminal justice system can benefit because, once sanctions and rewards are brought into treatment plans, control can be extended and clients are managed more easily.

Substantive incentives, such as reduced jail time or less frequent reporting to parole or probation officers, can encourage offenders to participate in treatment. Offenders also may benefit from knowing that there are or can be advantages for making progress in treatment. Incentives can be used to encourage treatment participation at several points in the criminal justice continuum, starting at arrest and pretrial procedures. Offenders should know that if they enter treatment, alternative sentences may be imposed. Other examples of incentives are safe housing units, additional recreation time, positive parole board review, and the return of children to their mothers. Incentives also can be used to the treatment program's advantage.

Most research, including several very large studies, has shown that participation in methadone treatment is associated with a reduction in illicit opioid use, a reduction in criminal activity, increased employment, and improvement in psychological status. In addition, those involved in methadone maintenance treatment receive social, vocational, legal, and educational support services.

Conclusions: The Importance Of Linkages and Joint Decisionmaking

As emphasized throughout this document, effective linkages and partnerships are necessary to enhance the relationships between treatment and each stage of the criminal justice continuum. As discussed in the previous chapter, such partnerships can take many forms, including committees, programs, policies, resource materials, manuals, and laws. Both systems must recognize the

importance of a unified approach to the problems created by AOD abuse and criminal behavior. In addition, they must acknowledge the need for many groups and agencies to become involved in collaborative activities to reduce AOD abuse. As an offender moves through the criminal justice continuum, there are increasing linkage needs, not only between the criminal justice and treatment systems, but also with other community services and programs.

Endnote

1. David Brenna, M.S., from the Department of Social and Health Services in the State of Washington, contributed to this chapter.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Chapter 6 -- Collaboration Between Systems ³

The criminal justice system and the alcohol and other drug (AOD) abuse treatment system can work together. Creating a coordinated approach involves change that is often difficult. The goals of effective collaboration should be improving AOD abuse treatment for offenders, reducing recidivism, and improving public safety. This chapter addresses issues that arise when planners consider the integration of AOD treatment and criminal justice services. Conditions for an effective collaboration are outlined, and steps in a strategy to implement system change are described. A systems planning approach to coordinate AOD treatment services for offenders is discussed.

The planning process should include representatives from a variety of stakeholder groups. This chapter describes stakeholders in five primary areas whose potential contributions to the planning process should not be overlooked.

Memorandum of Understanding

When an AOD program and a criminal justice agency attempt to establish an ongoing relationship, it is best to have a complete discussion about the objectives of each partner, the expectations each partner has about the obligation of the other, and communications between the program and the criminal justice agency. For programs treating offenders, it is crucial to identify who will make certain decisions and what kinds of information will be reported. For example, will the program or the criminal justice agency decide when an offender's relapse into alcohol or drug use will be handled as a violation of the conditions of probation? How detailed are the program's reports to the criminal justice agency? Matters such as these should be resolved up front between the program and criminal justice agency to avoid problems later. A memorandum of understanding (MOU) or letter of agreement should be drafted to set forth the responsibilities agreed upon by each system. A sample interagency agreement that lays out such basic responsibilities is included in [Appendix C](#).

System Interdependence

The criminal justice and AOD systems can cooperate to improve the results of both systems. A basic principle of all systems is that every part of the system has an impact on the other parts.

This impact occurs at the "street" level and the policy level. A lack of coordination and integration at the street level can cause system failures and may affect treatment outcomes. If AOD assessments of offenders made by different treatment staff have conflicting results or if the assessor does not relay AOD abuse information about the offender to the criminal justice officer, the system is failing. If the therapeutic community treatment program does not know about the offender's criminal history, the system is failing.

Policy failures are not as obvious as street-level failures, but they are more harmful. For example, a decision that results in inadequate funds for AOD treatment will increase recidivism. Failure to enact enabling statutes while enacting prescriptive statutes reduces the ability of both systems to provide effective treatment. Failure to include juveniles in legislation mandating treatment for offenders hurts young people. Having a policy that without exception revokes an offender's parole for a single positive urinalysis can detract from treatment success. Treating only the "easy to treat" gives false hope.

Fortunately, both street-level and policy failures can be avoided. The remainder of this chapter describes steps to promote integration between the criminal justice and the AOD treatment systems to achieve increased effectiveness.

Conditions for Effective System Relationships

[Argyris \(1973\)](#) has argued that five conditions must exist for effective intergroup relationships to occur across systems. The following principles and examples apply to the criminal justice and AOD systems:

- **Members are concerned about their own group or system's effectiveness.** Representatives of the criminal justice and AOD systems must show commitment to the effectiveness of their own system and its departments or groups.
- **Members have confidence in their own group or system.** Members should find their group attractive and relevant to their lives. It is not enough for the group members to see their group or system as effective. They must find it personally attractive and important. If they do not approach it this way, systems linkages cannot occur.
- **Members believe in the interdependence of the other system and their system.** Members must be aware of their group's interdependence with other groups. For example, members of both the criminal justice system and the AOD treatment system should recognize that addicted offenders can benefit from treatment. At least two members or agencies, one from each system, should be aware of this interdependence and be committed to making the linkage between systems work at the highest levels in their organizations.
- **Members are willing to accept or develop a superordinate goal to link the systems.** In the collaborations between the criminal justice and AOD systems, there must be a direction common to both embodied in a unifying goal that can be reached only through interactions between the systems. Members must have a common mission, a common vision, and common guiding principles. The vision must involve the two systems moving together in the same direction.
- **Members are willing to interact with other groups in other systems in coordinated joint ventures.** There should be a willingness to cooperate among the relevant community-based and policy-level participants and the accepted coordinating body. A willingness to provide adequate

funding across agency boundaries is also a key element.

If all these elements are in place and a superordinate goal is agreed upon, then the interlinking groups can develop processes to foster desired changes in their own systems.

The Process of Integrating Systems

Strategies for Change

The following section presents basic principles that have been used to effect change in a variety of organizations and systems. Examples are given showing how they can be used in integrating the criminal justice and AOD abuse treatment systems.

Primary leaders or their designees with system power should be enrolled in a change effort.

A group of five to seven persons who have the confidence of their leaders and which includes representatives of both the criminal justice and the AOD systems should participate in efforts for system change. This small group should develop an agenda for action. The Criminal Justice Treatment Planning Chart prepared by the Center for Substance Abuse Treatment (CSAT) ([see Appendix B](#)) can serve as a frame of reference. In the chart, one (or more) specific connections between the criminal justice and the AOD treatment systems should be targeted. A preliminary goal that links the two systems should then be established. It might be a modest goal if the group has not worked together, and it should be one that is attainable. Building on small successes at the beginning of the process is important.

The group should obtain formal endorsement from both systems' leaders if endorsement is not implicit. Endorsement may be implicit if leaders are part of the group; however, if they are not, formal endorsement is necessary. This endorsement can take the form of an executive order from the governor, mayor, or commissioner; a legislative declaration for the group's work; or simply an information "sanction" from those who hold power in the criminal justice and AOD treatment systems. Those in power can either stop the project or support it. Whoever sanctions the work must be kept informed about progress and goals at every stage, preferably in an informal, uncomplicated way. Good personal relationships can help. Individuals with power should be shown how they can support the systems' mutual efforts. The group should learn how these individuals' agendas might overlap with system integration agendas. They should be shown how integrating the criminal justice system and the AOD abuse treatment system is complementary to their goals.

A unifying goal must be present. The planning group must set a unifying goal. This goal must encompass the needs of all parts of the AOD treatment and criminal justice systems that are affected. For example, a goal to reallocate money from current treatment programs in order to treat other groups of offenders is not an overarching goal. However, a goal of finding new funding for offender treatment that focuses on the most dangerous offenders is an example of a superordinate goal. The process of articulating goals will help work out differences between group members and further the process of group norm setting.

Objectives must be described. As soon as the goals have been determined, objectives must be

described. As with any problem-solving process, a series of concrete objectives must be established with action plans to achieve the goals agreed upon. The objectives should then be assigned to individual group members for followup.

The group should conduct a stakeholder review. Members should develop a list of all stakeholders who could have an effect on achieving the goal. Later in this chapter, five groups of stakeholders are described. Any individual or organization with an interest in integrating the systems, or that will be affected by the change, can be considered a stakeholder. In addition to representatives of the two systems involved, examples include planners, policymakers, representatives of the general public, and offender advocacy groups. The group should select 20 percent of stakeholders who could help reach 80 percent of the goal. Helpful stakeholders, as well as those who would ordinarily work against the goal, should be included.

Difficult people must be included. As the criminal justice and the AOD abuse treatment systems begin to work together more closely, "difficult" people will be encountered. It is most important to include them in the process. Often, they are difficult because they care very much about what is being proposed or because they think there is a chance their status or livelihood will be affected. The only time the group should think about fighting the difficult people is when it is certain that they oppose the superordinate goals of the integrated group.

Data must be collected. Information about the behavior of both systems is critical to the group in determining specific goals and objectives. For example, the CSAT Criminal Justice Treatment Planning Chart ([Appendix B](#)) pinpoints nine potential linkage points between the systems: arrest, pretrial hearing, presentence hearing (plea), jail, diversion program, trial/sentencing, probation, jail/prison, and parole. Data about what is needed to create, maintain, and improve linkages at each of these points can be collected. The types of data that will be most critical will vary according to location. However, some general examples are given in the following paragraphs:

- *Arrest:* The group can obtain data on the number of drug-related arrests, the number of police officers who are involved in making arrests, and the number who may require training in AOD abuse information. This information is useful in developing an awareness of the scope of the problem in a particular locale and the resources that are needed to address the problem.
- *Pretrial hearing:* The group can gather information on the number of arrestees who are detained in jail after arrest and their lengths of time in jail. Specific information about these individuals, such as the results of laboratory tests for alcohol and other drugs, will indicate the extent of resources needed to make a variety of interventions, from detoxification to AOD education. Data about jail staff, such as information about their skills and knowledge of AODs and about the jail facility itself, including typical daily activities, can help planners from the AOD treatment system understand the potential and limitations for making interventions in this setting.
- *Presentence hearing (plea), jail, diversion program:* At the presentence stage of the justice continuum, many AOD-involved offenders can be effectively placed in diversion programs. (See the Treatment Improvement Protocol [TIP] in this series, *TIP 21: Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System*.) To determine what proportion of offenders may be appropriate for diversion, data about the number of AOD-involved offenders and the nature of their crimes are needed. Data on the number who are recidivists can be valuable in persuading policymakers about the need for an approach that

includes AOD abuse treatment. To plan effective interventions in the jail setting, data about AOD-involved offenders who are held in jail until their trial is useful, including information about the size of this group and the severity of their addiction. These offenders probably have longer jail stays, allowing for more intensive interventions when appropriate.

- *Trial/sentencing:* Effective linkages between the two systems depend to a great extent on judges' knowledge of AOD abuse treatment and the appropriateness of different modalities of treatment for offenders with different AOD-related problems. Data about the number of judges, their sentencing records, and their knowledge of treatment are useful in helping planners understand the resources that will be needed to train judges and other court personnel about a variety of treatment options and how to use them.

Plans for the expenditure of all State and local AOD treatment funds should be examined and compared with plans for AOD treatment programs. Several issues should be considered. Are AOD funds being focused consistently on the stated expenditure plans? How can AOD treatment plans be changed without decreasing their effectiveness? Where is the flexibility in the AOD treatment system that can permit the channeling of funds and resources to treatment in the criminal justice system?

- *Probation:* As described in [Chapter 4](#), probation officers can make a critical difference in ensuring that AOD-involved offenders comply with treatment and avoid recidivism. To plan linkages at this stage of the continuum, data about probation officers, including the size of their caseloads and their knowledge of AOD abuse treatment, are useful. Because case management is also important at this stage, data should be gathered about the number of AOD-involved offenders on probation and their characteristics and needs.
- *Jail/prison:* Data about the number of incarcerated AOD-involved offenders and their characteristics are essential in planning treatment programs in these settings. The number of women incarcerated for AOD-related crimes is increasing, and many women who enter jail or prison are pregnant and have special needs for AOD treatment services.
- *Parole:* Parole officers can help offenders maintain the gains they have made during treatment while incarcerated. Data about their knowledge of AOD abuse treatment, as well as data about the population of parolees in a given area, are useful to planners.

To gain additional planning information, the group should examine documents related to statewide and, if appropriate, countywide planning. These documents contain a wealth of information about many AOD problems. Data can be included from the Drug Abuse Warning Network (DAWN) hospital emergency room survey, the Monitoring the Future Survey, and the National Household Survey, published each year by the National Institute on Drug Abuse, and the Drug Use Forecasting (DUF) System, established by the National Institute of Justice. While most of this information will not be specific to offenders, it can be used to help lay the groundwork for an action agenda among criminal justice and AOD treatment system personnel. Using these data, the group can extrapolate the extent of local substance abuse problems. The group should analyze and discuss all data and plans to ensure that the work of integrating the systems does not conflict with AOD treatment activities in progress.

In addition, plans for the expenditure of all State and local AOD treatment funds should be examined and compared with plans for AOD treatment programs. Several issues should be

considered. Are AOD funds being focused consistently on the stated expenditure plans? How could AOD treatment plans be changed without decreasing their effectiveness? Where is the flexibility in the AOD treatment system that could permit the channeling of funds and resources to treatment in the criminal justice system? Where do data related to the needs for AOD abuse treatment coincide with needs for criminal justice treatment? What are the major problems in the AOD treatment system? What are the additional data needs in the AOD system?

Exactly the same data collection process that is done for the AOD system must occur for the criminal justice system. All plans relating to drug-involved offenders, together with existing data, should be reviewed. These data may include DUF data and data on numbers of positive tests for various drugs. Data should be collected from all the probation, parole, jail, prison, and community corrections programs in the target area. Funds allocated to treatment of offenders should be specifically identified and cataloged.

Data should be used for decisionmaking. Once data are collected, comparisons with data from other jurisdictions and States can be made for each of the nine system linkages. Areas of greatest need can be identified. For example, it may be found that one county administers drug tests to serious offenders significantly more often than another county does, and the group may decide to focus on that issue.

Data and plans should be summarized for the policy group. Often, a systemwide analysis of plans and data will identify major areas of group agreement. Another way to identify goals is to do a "what's missing" analysis for each institutional unit within the criminal justice system. At the local level, this analysis might include forming focus groups with probation officers, jail personnel, parole officers, and community corrections personnel to find out what steps each group thinks should be taken. At the State level, focus groups could be conducted across the State for probation, parole, community corrections, and prison personnel.

Feedback from focus groups, as well as the collected data and plans, can all contribute to the policy group's decisions about the size, seriousness, and locus of the problem. From this information, goals can be identified. Goals must be obvious and based on the data, plans must be studied, and the information must be gathered from the focus groups.

System descriptions should always be made. Simply describing how the system actually operates at a specified time can often be a powerful tool in demonstrating linkage problems. This process can be accomplished with computer assistance and flow charts to illustrate systems and/or processes. The process of interviewing key players in a system and discussing the proposed system flow will often elicit important feedback. This feedback is essential for a properly operating system.

Sensitive Areas Hindering System Integration

Sensitive points can hinder system integration by creating conflicts between systems and discouraging participants in the linkage process. Sensitive areas include

- **"Creaming"** -- Creaming means treating the easy-to-treat in place of the hard-to-treat. To avoid

this problem, both systems must agree on a clear, objective assessment of offenders' needs. This assessment should classify offenders based on their probable need for treatment.

- **Lack of resources** -- Lack of resources is a serious problem. In most States and local jurisdictions, limited new funds are available for treatment. Turf conflicts may thus arise, some of which may be intense. Several approaches exist to deal with a lack of resources. It is important that there be agreement about the type of offenders who should receive resources first. A surcharge specifically for AOD treatment can be added to the fines of AOD-abusing convicted offenders. Another approach is to reallocate resources from inpatient to outpatient treatment or to intensive outpatient services. Such reallocation should be done only if assessments agreed upon indicate that it would create more effective services.
- **Doing nothing** -- The absence of action can cause a major conflict for those who wish to see the systems linked. Integrated system thinking as proposed in this chapter can be used to overcome such problems.

Collaboration Among Stakeholders

The hard work of planning AOD treatment for offenders in any part of the criminal justice system continuum will be carried out by the leaders in the criminal justice and AOD systems. Policy, procedures, relationships, and shared responsibilities will be developed to operationalize effective AOD treatment within the criminal justice system.

Leaders in the criminal justice and AOD systems should not make the mistake, however, of being noninclusive. Many individuals and stakeholders will be affected in some way by the development of integrated criminal justice-AOD treatment programs. Stakeholders may include the citizen who depends on the local police department to keep the neighborhood safe, the professional in the social service agency who is concerned about the welfare of the offender's children, and the crime victims who want to see criminals punished. Organizations such as churches, youth programs, and businesses may view the criminal justice system from different perspectives. They too are stakeholders in the criminal justice system. Taxpayers are stakeholders who finance criminal justice system programs and often AOD abuse treatment programs. These and other stakeholders should be taken into consideration when an AOD abuse treatment program is being planned. Even the best planned program will not succeed if local citizens and taxpayers oppose it. In addition, public support and involvement can provide the momentum needed for programs to pass from the planning stage to implementation.

It is important to obtain stakeholders' involvement early in planning for treatment capacity. Members of the affected groups can make major contributions to strengthen new programs. For example, AOD abuse treatment programs refer patients to human service agencies for necessary auxiliary services. If these agencies are represented in the planning group, they can assist in the design of referral policies and procedures that optimally benefit the AOD abuse treatment program, the criminal justice system, the offender, and the community.

There are two broad categories of stakeholders: 1) those with an influence over the decisionmaking processes and 2) those who are affected by the decisions. The degree to which stakeholders have influence or control in the decisionmaking process varies, as does the extent to which a decision has an impact on each stakeholder. For example, the child of an offender has

little influence over a decision but can be greatly affected by it. On the other hand, a prosecuting attorney may have great influence over the decisions made about an offender, but such decisions may have little impact on the prosecutor.

Even the best planned program will not succeed if local citizens and taxpayers oppose it. Public support and involvement can provide the momentum needed for programs to pass from the planning stage to implementation.

It is helpful to divide stakeholders into five basic categories:

- Community stakeholders
- Stakeholders associated with the offender
- Stakeholders within the criminal justice system
- Stakeholders within the AOD treatment system
- Stakeholders within the public health system.

Community Stakeholders

The Public

The public may influence what happens at every point along the criminal justice continuum. The importance of informing the community about AOD treatment and criminal justice issues cannot be overemphasized. Many individuals and groups, including the voting and nonvoting public, have different influences and needs. The electorate can be considered to have more clout than the nonvoting public and is therefore in a position to wield greater influence over decisionmaking.

In addition to educating the public about needed changes, it is vital to let the public know what is working. For example, officials responsible for overseeing each stage of the criminal justice system might consider releasing a community annual report, similar to a corporate annual report, that includes facts such as the number of people who have successfully completed a treatment program. Such successes may allay some of the public's fears about offenders. It is important to help the public understand that providing treatment to offenders is not being "soft on crime" and that these programs do not overlook the primary justice system responsibility of protecting public safety. When members of the public participate in planning, this ongoing educative process is initiated.

Victims

Those victimized by a crime include the crime victim and family members -- especially children -- and significant others. Several States have passed constitutional amendments to protect the rights of victims. These amendments usually provide an opportunity for the victim to take part in the criminal justice process. In a number of jurisdictions, community-based victims' rights groups have also been established. Some prosecutors' offices employ victim advocates, who should also be included as stakeholders in the planning process.

Victims have a variety of interests, depending on the circumstances of their cases. Most victims want punishment, restitution, and protection. For their protection and the protection of other potential victims, they may want the offender removed from society and punished. They may also want to see the offender's AOD problem addressed. Many victimization circumstances are not direct, as in the case of persons who live across the street from a crack house and whose main goal is to close it down. Some victims may want every opportunity possible to represent their own interests, while others may prefer to have nothing to do with the criminal justice system.

The general public may influence what happens at every point of the criminal justice continuum. The importance of informing the community about AOD treatment and criminal justice issues cannot be overemphasized.

Media

The media play a major role in shaping public attitudes toward the criminal justice system, especially attitudes about how to handle AOD-involved offenders. Personnel in the criminal justice and AOD treatment systems should always be aware that the primary goal of those in the media is to get a good story. This objective often plays out in stories that expose weaknesses and failure in human systems. Few events make bigger headlines or splashier leads for the evening TV news than the violent crime committed by an offender who has been returned to the community. Television news, in particular, will often spend the first 10 minutes of a broadcast reporting stories of violent crime, without considering the impact of these stories or putting them within a balanced context. Such reporting may have the effect of creating an adversarial relationship between the media and the criminal justice and AOD treatment systems.

Avenues of communication between the media and the criminal justice and AOD abuse treatment systems must be kept open. Continual efforts should be made to communicate a full picture of the multifaceted issues surrounding crime, substance use disorders, and AOD treatment. AOD and criminal justice system personnel should take a proactive approach and work with the media, rather than just reacting to negative stories about crime and drugs. When media representatives are involved in planning, they may begin to see the positive side of joint efforts of the criminal justice and AOD abuse treatment systems.

Legislators

Legislators should be consulted and educated about the addicted offender in the criminal justice system. It is important that they become aware of success stories, so that the overwhelming influence of failed cases does not dominate their policy decisions. The political stance of being "tough on crime" and "waging war on drugs" has resulted in legislation requiring mandatory sentences for drug offenses, which must be tempered with a well-informed view of positive treatment outcomes.

Community Organizations

Community groups include local boards, recreational programs, church groups, neighborhood

watches, and other community associations that address either directly or indirectly the issues of AOD abuse and criminal behavior. These groups can play a role in prevention, treatment, and referral. Advocacy groups such as Mothers Against Drunk Driving (MADD) and other special interest groups also can work effectively at the community level to address prevention issues. Their agendas are often tied to those of other community groups that can be helped to understand the importance of reaching offenders with effective treatment.

Businesses

Local businesses and business groups, such as Kiwanis, Rotary, and downtown business associations, have a very strong interest in preventing crime, since they may be targets. They often take a strong and active role in their communities. Employers may also be interested in preventing AOD abuse by their employees. Vocational training is an important component of helping AOD-involved offenders reenter the community. Business leaders can provide invaluable assistance in planning training programs and providing opportunities for job placements. Businesses, as a vital component of the larger community, should be involved in planning for AOD treatment in the criminal justice system.

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Stakeholders Associated With the Offender

The Offender

A review of the AOD-abusing offender's needs can highlight the difficulties associated with effectively treating and rehabilitating this population. Offenders usually want as little intervention in their lives as possible. They do not want to go to jail. In addition, offenders who are actively using drugs at the time of arrest may not be very interested in treatment. Many offenders want to continue using drugs and may deny their AOD problems. However, once the effects of AODs dissipate, remorse, depression, or anger may set in for some offenders, and they may be more open to treatment. Mandated AOD abuse treatment in a community setting with justice system supervision can be an alternative to incarceration for some offenders.

Family Members

Relatives and significant others often want to change an offender's behavior. However, many offenders come from dysfunctional or marginally functional families, where their efforts to change may be undermined. A multigenerational approach can be used in an attempt to work with the family system. If there are treatment opportunities available for the offender in the criminal justice system, family members may believe that arrest is the best thing that could happen. Some family members may also believe they need protection from the offender, especially if domestic violence is an issue. The interests of female offenders with children should also be taken into account when a treatment decision is made.

Employers

Many offenders lose their jobs when they enter the criminal justice system. However, some employers may be willing to support an offender by allowing the offender to keep his or her job during the presentencing stage and later if the offender is put on probation. Employers can participate in the pretrial investigation and support appropriate treatment for the offender. Some employers are becoming aware that they can play a strong role in the treatment process of their employees. Such employers may participate in probation or parole planning. Their support can make a significant difference in treatment outcomes for the offender.

Once the effects of AODs dissipate, remorse, depression, or anger may set in for some offenders, and they may be more open to treatment. Mandated AOD abuse treatment in a community setting with criminal justice system supervision can be an alternative to incarceration for some offenders.

Social Service Providers

Offenders entering the criminal justice system are frequently known by a variety of social service providers through school programs, recreational activities, and public assistance programs. These providers have an interest in the disposition of an offender's case, and the presentence investigators can bring them into the process. Once an offender has been found guilty, specific social service systems may become involved. For example, child protective services may become involved when offenders have dependent children, or immigration services when offenders are illegal immigrants. It is often helpful if the offender's involvement in such programs is known before sentencing. Presentence investigation should uncover this information.

Stakeholders Within the Criminal Justice System

Police

As described in [Chapter 5](#), community policing programs can be crucial components in preventing both crime and AOD abuse. Such programs should be holistic, providing services in many different areas. For example, police can work with the schools to reduce absences of children who are at risk of developing AOD problems, and they can visit the children's homes and connect mothers and other childcare providers with AOD abuse treatment programs. For example, police can alert outreach workers to individuals who need services. Some treatment programs and other service agencies have outreach workers who spend time in the community visiting schools, homes, and community groups to educate people about their services.

It has been shown that individuals are more likely to stay in AOD treatment if they are provided with support services such as primary healthcare and transportation. Police can perform an important role in connecting people with social service agencies, where individuals and families can obtain needed services. Police can be mentors and role models for youth in the community. Some officers have had success with "homesteading" -- actually living in the community they serve and becoming an integral part of the community.

It is usually the police who provide the entry point for an offender into the criminal justice system, and police will want to see that both systems support their actions. Police can also contribute valuable preliminary screening data, based on their assessment of the offender's condition at the time of arrest.

Pretrial Service Agencies

Once an offender has been arrested and charged, pretrial service agencies become stakeholders. Their charge is to gather information that will be used by the court in setting pretrial release conditions. In most States, the court is required to set the least restrictive conditions that will reasonably ensure the defendant's return to court and the protection of public safety. Pretrial agencies thus serve a supervisory function and are responsible for ensuring that the offender returns to court as ordered, that he or she does not commit another crime, and that AOD use is minimized. These responsibilities may include periodic reporting, curfew supervision, and drug testing.

Police can perform an important role in connecting people with social service agencies, where individuals and families can obtain needed services. Police can be mentors and role models for youth in the community. Some officers have had success with "homesteading" -- actually living in the community they serve and becoming an integral part of the community.

One example of a comprehensive pretrial services agency is in the District of Columbia, where an average of 100 new cases are processed every day, and 72 percent of defendants are released on their own recognizance or on supervised release. (Seventy percent of arrestees are released at first appearance. Another 10 percent are released at a later time.) Urinalysis of all defendants in this system is conducted, and over half show evidence of recent drug use. These defendants are either placed in a regular urine-testing program on an order to refrain from drug use or are sent for an AOD assessment. This agency also serves as a bridge between the court system and the AOD treatment system.

Treatment Alternatives to Street Crime (TASC)

TASC programs can be a bridge between the AOD treatment system and the criminal justice system. In some jurisdictions, TASC functions as a bridge between prosecution, probation, parole, and the AOD abuse treatment program.

Prosecutors

Prosecutors want to ensure that laws are enforced and that order is maintained within their community. Their goal is usually to obtain a guilty plea or conviction as quickly as possible. In many jurisdictions, the prosecutor's office faces a backlog of criminal cases, and prosecutors are pressed to move cases through quickly and to avoid wasting resources. Plea bargaining is frequently used to accomplish this goal.

Defense Attorneys

Defense attorneys play a critical role in the criminal justice system and may link the client to the AOD treatment system. In representing their clients, defense attorneys may face the ethical dilemma of deciding whether to do what their client demands or what they feel is in their client's best interests. Such a dilemma occurs when a client refuses to acknowledge an AOD problem. To provide a client with the best defense, attorneys may choose to ignore the client's potentially destructive AOD abuse in order to obtain the mildest sentence possible. If an offender is not being held in a detention facility, the defense attorney may feel it is in the client's best interests to get the case postponed for as long as possible.

Despite the necessary emphasis on defending their clients, defense attorneys may also see a need to facilitate change for some clients. Some defense attorneys are becoming concerned because they see the same clients repeatedly. They may encourage treatment to break the criminal cycle. Although clients may be opposed to entering treatment, defense attorneys realize that treatment participation can be a valuable asset in arguing for a reduced sanction. Many defendants may be in denial not only about their AOD abuse but also about their criminal charge.

Judges

Judges are key figures in any linkages between the criminal justice and AOD treatment systems. Judges work to see justice served, helping the offender whenever possible and moving the offender to trial quickly. As the interrelated needs of the criminal justice and AOD treatment systems have become apparent, some judges have recognized the necessity of taking time to apply graduated and intermediate sanctions to change behavior, rather than relying on all-or-nothing sentences. To make their decisions, judges want information that is usable, relevant, and as concise as possible. They need information about the offender, available treatment resources, and the success rate of offenders and others in such programs.

Judges are also interested in managing court caseloads and disposing cases. AOD treatment interventions may conflict with these goals by prolonging the time necessary to manage a case. Like others in the justice system, judges may need time to see the evidence that shows that treatment interventions will reduce recidivism and will thus dispose of cases more effectively over the long term.

As the interrelated needs of the criminal justice and AOD treatment systems have become apparent, some judges have recognized the necessity of taking time to apply graduated and intermediate sanctions to change behavior, rather than relying on all-or-nothing sentences.

Presentence Investigators

Presentence investigators gather information about the offender and provide the court with information about resources available to treat the offender. They also make a sentencing recommendation. In some cases, the probation officer writes the presentence report and may have a role in supervising the case. Probation officers who supervise cases want to see a

particular outcome for an offender and will recommend specific approaches such as urine testing or supervised curfew. Their goal is to set up a community control-and-treatment plan for the offender.

Probation Officers

Probation officers supervise offenders who are found guilty and placed on probation. They ensure that offenders comply with conditions imposed by the court at the time of sentencing. Probation should not be viewed as an alternative to incarceration, but rather as a sentence in its own right; (incarceration should be reserved for the most dangerous or serious offenders). The probation sentence allows offenders to remain in the community under the supervision and guidance of a trained probation officer or case manager. During probation, offenders are helped to deal with issues, such as substance abuse, that contribute to criminality.

Parole Officers

Parole officers are involved in supervising offenders who are released from prison before completing their full sentence. Stipulations and prohibitions on certain activities are made. Parole is supervised by a Board of Parole. Various approaches, such as intensive parole, have been used to supervise specialized drug caseloads.

Correctional Facility Administrators and Staff

Correctional administrators, officers, and other prison staff can play an important role in AOD treatment. Every opportunity should be provided for offenders to initiate and complete effective treatment within correctional facilities. Correctional staff should have an appreciation of treatment goals and how treatment programs can be designed so that security requirements and other correctional institution needs are met.

Stakeholders Within the Public Health and AOD Treatment Systems

Treatment providers and support staff have a stake in treatment outcomes. They want individual offenders whom they treat to succeed in achieving recovery. AOD treatment service providers perform different roles, depending on whether services are community based or based within a correctional facility.

Treatment providers from a range of modalities and settings should be included in the planning process. Examples include inpatient and outpatient detoxification programs, residential programs, day hospitals, methadone clinics, and therapeutic communities. Both program administrators and front-line direct-service providers have much to contribute to the planning process. Professionals and paraprofessionals from a variety of disciplines are involved in AOD treatment, and these disciplines should be well represented in the planning process.

Healthcare Organizations

Healthcare organizations can be partners in the comprehensive treatment of AOD-abusing

offenders. Given the high incidence and risk of human immunodeficiency virus (HIV) infection, tuberculosis (TB), and sexually transmitted diseases (STDs) in the offender population, public health departments have an increasing interest in working with the AOD treatment and criminal justice agencies serving these populations.

Healthcare providers in a community see daily evidence of the damage caused by AOD abuse and violent crime. Examples of such providers include primary care physicians, emergency department personnel, emergency medical services (EMS) teams, visiting nurses, and home healthcare workers. HIV disease service organizations often provide critical healthcare services. All these provider groups should be represented in planning AOD treatment for offenders.

Mental Health Organizations

Mental health practitioners can help identify and treat offenders who need psychiatric care in order to comply with AOD abuse treatment. Mental health organizations can play a role in keeping offenders in the community and out of hospitals or psychiatric institutions.

Both program administrators and front-line direct- service providers have much to contribute to the planning process. Professionals and paraprofessionals from a variety of disciplines are involved in AOD treatment, and these disciplines should be well represented in the planning process.

Coordinating Activities

To effectively conduct collaborative efforts with stakeholders, leaders in the criminal justice and AOD treatment systems are well advised to create two types of groups:

- Policy committees charged with suggesting and advising on linkages for the criminal justice and AOD treatment systems
- Operational committees to provide advice on treatment programming and criminal justice supervision.

These committees should have a dual focus on the complex individual needs of the offender and the need of the community for accountability, security, and sanctions.

Program Development

Generally, the most specific client-focused coordination occurs locally; but since States legislate, oversee, and fund many local programs, State-level policy coordination and planning are essential.

At the policy level, representatives from the following groups can be included:

- Corrections officials
- Local government officials
- Probation officials

- Parole officials
- Public defenders' offices
- Jail administrators
- Police and sheriff associations
- Prosecutor associations
- Treatment providers
- State AOD abuse treatment agencies
- Community AOD abuse treatment agencies
- Employment and vocational rehabilitation services
- Child welfare services
- Court personnel (or some kind of judicial representation)
- Community-based service organizations
- Health and mental health organizations.

Coordination should take place from the top policymaking levels to the direct service staff. Agreements should be worked out at upper levels to determine how collaboration will begin. These agreements should address negative attitudes and turf issues. Using the two-tiered committee structure mentioned above, communication and information exchange, interagency cooperation, and cross-training can be targeted on multiple levels. An ongoing interagency group should meet regularly to solve problems as they surface. An oversight committee can provide a forum for presenting issues.

Although information sharing is desirable, it is often problem driven. Collaboration should be institutionalized. "Forced networking" through State and county laws and ordinances can determine when and how often a coordinating group should meet. Interagency coordination can also be enhanced by including local service providers and providing a forum to handle issues that surface when dealing with clients who have multiple problems.

An integrated management information system can greatly enhance linkages between the criminal justice and AOD treatment systems. In addition, the data gathered can be used to monitor treatment outcomes and assess the effectiveness of the integrated systems.

Several jurisdictions have established coordinating groups. They include

- The Los Angeles County Criminal Justice Coordinating Committee, which meets monthly to discuss issues of importance to the criminal justice system. This multiagency committee is chaired by a judge and has an executive director. The committee's membership includes the full range of criminal justice stakeholders.
- Detroit has a similar coordinating body, but it is more informal. Several people involved in the criminal justice and sentencing processes meet regularly to discuss common problems and possible solutions.
- The Colorado Criminal Justice Commission established a process for corrections, public safety, AOD treatment, and the courts to cooperate in the assessment, treatment, and monitoring of AOD-involved offenders.

Ongoing Issues

Some would argue that coerced treatment, even of offenders, conflicts with American values of freedom of choice and noninterference by government in personal lives. However, even when coerced, AOD abuse treatment is effective.

The criminal justice system imposes sanctions for a certain period of time, while the AOD treatment system works with a client for an indeterminate length of time until he or she can achieve and maintain sobriety. The challenge is to look for creative ways to apply sanctions and provide incentives for offenders to continue treatment after their involvement with the criminal justice system.

Treatment Availability

Despite the obvious need for a wide range and large number of AOD treatment programs, both in the community and in correctional facilities, appropriate treatment programs are not always available. Availability varies by community and by setting. For example, one jurisdiction may have insufficient AOD treatment in the community but may have excellent AOD treatment programs in both jail and prison. Another jurisdiction may not provide any treatment in its jails but have a range of services available in the community.

Not enough treatment slots are available at any given time for those needing treatment. In addition, the available AOD treatment programs in the community may lack appropriate and necessary controls for the criminal justice client. Offenders who are screened, assessed, and recommended for treatment need services until a treatment slot becomes available. Day reporting centers, where clients attend every day and take advantage of a variety of programs, are a short-term solution for those awaiting treatment.

Undue Influence

Judges should discourage "lobbying" by representatives of specific programs. It is not a judge's role to assess programs or the suitability of an offender for a particular program. But judges should understand the value of different types of treatment in order to be able to fully understand available placement alternatives. Judges should advocate for outcomes-based program evaluations to better inform decisionmaking processes.

Efficacy of Mandated Treatment

Research has shown that mandated treatment works. ([Chapter 1 of this TIP](#) provides a review of research in this area.) However, some treatment providers are not accustomed to working with offenders. Criminal justice personnel may feel that some providers are too quick to conclude that an offender is not going to benefit from treatment. This particular problem is common and not insoluble, although the existing system was not established to provide a solution. Pretreatment readiness programs can work for some offenders.

Implications of Urine Testing

An issue that must be addressed by both systems is how to respond to positive urine tests. Both systems must agree on the goals of testing and outline specific responses to positive tests.

Recommendations

Specific suggestions for State action plans include

- Identifying shared populations and determining top priorities common to both systems. Attainable goals should be articulated and a jointly funded program should be established to achieve the goals.
- Requiring cross-training for AOD treatment, criminal justice, and public health staff. Cross-training should include as many stakeholders as possible and should enhance effective
- collaboration between the systems.
- Developing and refining management information systems relevant to all three systems.
- Developing a system of waived offender information available to all three systems -- the AOD, criminal justice, and public health systems. The information could be used to improve AOD treatment, ideally reducing the risk of recidivism.
- Developing loose-leaf resource manuals so that new material and changes that are relevant to both AOD treatment and criminal justice systems can easily be added. The manuals should include descriptions of local services and contact persons.
- Publicizing successful examples of improved offender rehabilitation resulting from effective
- linkages between the AOD treatment and criminal justice systems. Such information should be publicized on an annual basis, and preferably more frequently.
- Involving the media in publicizing issues and specific examples of AOD treatment and criminal justice linkages. Collaboration with the media is crucial if systemic change is to occur.
- Encouraging linkages with State, local, and private resources to maximize efficiency and effectiveness in AOD programming.
- Encouraging case management as an important linkage activity. Combined case planning is
- another important tool for fostering collaboration between systems.
- Involving the community. Those involved in the criminal justice and AOD systems should continually promote education about possible solutions to problems. Schools, churches, and community organizations should be encouraged to become involved in fostering public education and public participation.
- Investigating possibilities for federally funded pilot projects that encourage and support the criminal justice, AOD treatment, and public health systems to work together collaboratively.

Endnote

1. Bill Woodward, a Facilitator for the Consensus Panel, and the Director for the Colorado Division of Criminal Justice, contributed to this chapter.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Chapter 7 -- Coordinated Training

This chapter discusses some training needs of staff in both the criminal justice and the alcohol and other drug (AOD) abuse treatment systems with the primary focus on coordinated training. Topics that should be included in training efforts are suggested.

To effectively administer AOD treatment within the criminal justice system, staff in both systems should receive cross-training. They should become familiar with the philosophy, approach, goals, objectives, language, and boundaries of both systems. Treatment providers should understand the importance of security issues, and criminal justice personnel should understand the dynamics of AOD treatment and its potential to reduce recidivism and relapse.

Joint training should be discussed and planned at the highest policymaking levels. Establishing and overseeing training can be an important responsibility for a criminal justice and AOD treatment coordinating council. Training is necessary for personnel at every stage of the criminal justice continuum. For example, police and pretrial officials should know about available AOD treatment options for different types of addiction. Judges and prosecutors also should be familiar with the range of treatment options and how AOD treatment plans can be adapted to an offender's particular circumstances.

Issues for systems that serve criminal justice clients include the following:

- Judges, prosecutors, and defense attorneys need to update their information about AOD community treatment programs and resources to refer defendants and offenders for treatment.
- Counseling staff should have specialized training about the multiple needs of offenders.
- Personnel in all parts of the criminal justice continuum should be knowledgeable about the types and benefits of AOD treatment. Examples of special target groups include States' attorneys, correctional personnel, and jail and prison administrators.
- Training for probation and parole officials should emphasize relapse prevention and

management ([see Chapter 5](#)).

- Training in the AOD treatment system may be targeted to parole boards and to State and county legislators. Parole boards are usually autonomous, with politically appointed members. These members often have other jobs or are recently retired, and they may vary in their knowledge and expertise regarding the criminal justice system, AOD abuse, and AOD-involved offenders. Legislators need current information about both systems in order to draft effective legislation.
- AOD treatment staff must be trained in the legal mandates and responsibilities imposed by the criminal justice system.
- Judges must have an understanding of addiction, craving, and relapse.

Cross-Training

AOD treatment providers must understand the goals of the criminal justice system in order to develop effective AOD treatment plans for offenders and to earn support from justice personnel. AOD providers should also understand the operational responsibilities of the justice system, the importance of public safety, and the security concerns that are at the heart of criminal justice. Many AOD treatment providers may have only a layperson's familiarity with the criminal justice system; may use such terms as *intermediate sanctions*, *diversion*, and *supervision* interchangeably; and may not understand the important distinctions between *arrest* and *arraignment*, and *parole* and *probation*.

Just as criminal justice personnel must understand the roles of AOD treatment program personnel and the different types and levels of AOD treatment, providers must understand the different roles and functions of justice system personnel. For example, they should have knowledge about the specific responsibilities of criminal justice personnel as cases flow from arrest through trial and sentencing, as described in the Center for Substance Abuse Treatment (CSAT) Criminal Justice Treatment Planning Chart ([Appendix B](#)).

Since the late 1980s, CSAT has provided technical assistance to States seeking to establish cross-training programs. Early efforts focused on training probation officers and treatment staff. More recent efforts have focused on creating multidisciplinary teams of staff from a spectrum of the systems that collaborate to engage and retain offenders in treatment.

Many of the Treatment Improvement Protocols (TIPs) in this series can be used or adapted for use in training staff in both systems. For example, the TIP entitled *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (TIP 10) has a chapter on identifying and treating persons with personality disorders, including antisocial personality disorder, which is a common disorder among offenders. The TIP provides materials for helping people with this disorder identify dysfunctional thinking and response patterns and work effectively in 12-step programs.

The TIP *Detoxification From Alcohol and Other Drugs* (in development) can be used to give staff a broad understanding of this step, which is the first in the treatment process for many persons. Intensive outpatient treatment may provide an appropriate community-based level of care for many nonviolent offenders, and the TIP *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* describes one approach to this level of care. The TIPs on *Pregnant Substance-*

Abusing Women, Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases, and Treatment for HIV-Infected Alcohol and Other Drug Abusers contain material especially relevant for work with offender populations. Many persons in the justice system may have a poor understanding of treatment with methadone or LAAM, and three TIPs describe current practices in this area: *State Methadone Treatment Guidelines*, *Matching Treatment to Patient Needs in Opioid Substitution Therapy* and *LAAM in the Treatment of Opiate Addiction* (in development).

Four other TIPs in this series address current efforts to link the treatment and criminal justice systems and would be especially useful in training treatment staff in justice system issues. These other TIPs are *TIP 7: Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*, *TIP 12: Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, *TIP 23: Treatment Drug Courts; Integrating Substance Abuse Treatment with Legal Case Processing*, and *TIP 21: Combining Alcohol and Other Drug Abuse Treatment Services With Diversion for Juveniles in the Justice System*.

Judicial Education

In order to make effective legal decisions, judges must stay informed about issues in many areas. Organizations such as the American Bar Association, the National Judicial College, the National Association of State Court Judges, the American Judicature Society, and the National Association of State Judicial Educators ensure that judges receive many kinds of information and training. Substance abuse may play a role in any case that comes before a judge -- not just drug-related offenses -- and recognizing its role can improve judicial decisionmaking. For example, settling some custody disputes requires judges to understand the dynamics of substance abuse in family systems. In making decisions about AOD-involved offenders, judges must understand the spectrum of addiction from both a medical and behavioral perspective, as well as the various types of interventions and treatments available. They should have knowledge of the dynamics of self-help groups and their role in recovery from AOD dependence. They should also receive information about the costs of treatment and various third-party payers, including private- and public-sector sources. Such basic information is the core of most AOD treatment education for judges.

In making decisions about AOD-involved offenders, judges need to understand the spectrum of addiction, from both a medical and behavioral perspective, as well as the various types of interventions and treatments available.

However, in addition, judges often need training about the extent of their authority to require offenders to participate in treatment or other types of interventions. Many judges are not aware of the extent of their authority to implement innovative sentencing alternatives. For example, in some jurisdictions judges have taken the initiative in establishing Victim Impact Panels in their communities. The panels are composed of victims of crime, such as individuals who have been injured by drunk drivers or the family members of those who have been killed. As part of an

offender's sentence, a judge requires attendance at one or several of the panel's sessions. At the session, victims of crimes speak directly to offenders about how their lives have been affected.

In addition, judges may benefit from discussions with peers about the extent of judicial responsibilities and how an individual judge's beliefs about these responsibilities influence his or her decisions; many training courses and workshops offer this additional benefit of peer support. Some training courses attempt to increase judges' understanding of the difficulties that an AOD-involved offender might have in accepting help for the AOD problem. Role-playing with peers may be used in this situation. Learning to offer help in a way that motivates a person to accept help can also be a training focus.

In a few States, AOD training for judges has evolved beyond basic information. In the State of Wisconsin, for example, judges also receive training in how to recognize "functional misfits," that is, individuals who may be functioning at a high level in some environments (for example, those who have reached important positions in their profession) but not in others (for example, those who may be physically or emotionally abusive with their families). The judges are taught to look for the strategies these individuals use to hide their dysfunction. The Wisconsin judges are also trained to recognize early signs of AOD abuse problems in lawyers and other justice personnel, including other judges, and to offer help in a way that is more likely to be accepted. Professional peer support and self-help play an important role in the training.

Targeted Training

Training can target such issues as the goal of prevention, Federal confidentiality regulations, relapse prevention, infectious diseases, cultural competence, and the high levels of stress experienced by those who work with substance-abusing clients. Each of these areas is described in detail in the following sections.

Prevention

Prevention -- of AOD abuse and crime -- is a primary goal of both systems. Prevention offers communities an opportunity to stop AOD problems before they start and provides hope for effecting community change to support healthy behaviors. While there is no single definition of AOD abuse prevention, there is general agreement on the positions taken by AOD practitioners on the overall principles of prevention:

- Alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal.
- Prescription and over-the-counter drugs are used only for the purposes for which they were intended.
- Other abusable substances are used only for their intended purposes.
- Illegal drugs and tobacco are not used at all.

Because AOD use plays a role in the transmission of human immunodeficiency virus (HIV) disease and a variety of other illnesses, the importance of prevention cannot be overemphasized. A key component of all prevention efforts is education. Personnel from both the AOD treatment

system and the justice system should receive prevention education and training in a variety of topics. They should also learn ways to enhance the prevention messages among offender populations.

Prevention Premises

Since 1986 the Center for Substance Abuse Prevention (CSAP) has provided guidance and leadership in the Nation's prevention efforts. From its efforts, several basic prevention premises have emerged that can form the basis for sound prevention training and education ([Center for Substance Abuse Prevention, 1993](#)). These premises are

- Prevention strategies must be comprehensively structured to reduce individual and environmental risk factors and to increase resiliency factors in high-risk populations.
- Community involvement is a necessary component of an effective prevention strategy.
- Prevention must be interwoven with general healthcare and social services delivery systems and it must provide a full continuum of services.
- Prevention approaches and messages that are tailored to differing population groups are most effective.

As prevention strategies have evolved over the last 20 years, several have proved effective, especially when used in combination:

- **Information dissemination.** This strategy promotes awareness and knowledge of the nature and extent of AOD abuse and addiction and the resulting effects on individuals, families, and communities. It also provides awareness of prevention policies, programs, and services. It helps set and reinforce norms (for example, drug dealers will not be tolerated in this neighborhood).
- **Prevention education.** The goal of this strategy is to affect critical life and social skills, including decisionmaking, refusal skills, critical analysis (of media messages, for example), and judgment.
- **Alternatives.** This strategy establishes constructive and healthy activities that do not include AOD use and encourages individuals to use alternative methods of meeting needs usually filled by the use of alcohol and other drugs.
- **Problem identification and referral.** This strategy calls for identification, education, and counseling for individuals, especially youth, who are at high risk of developing AOD problems.
- **Community-based process.** This strategy aims to enhance the ability of the community to provide prevention and treatment services more effectively. Activities include organizing, planning, enhancing efficiency and effectiveness of the implementation of services, collaborating with other agencies, building coalitions, and networking. Building healthy communities encourages healthy life-style choices.
- **Environmental approach.** This strategy sets up or changes written and unwritten community standards, codes, and attitudes to reduce AOD problems in the community. Included in this approach are laws to restrict availability and access, price increases, and communitywide actions.
- Topics for prevention training might include
- Discussion of needle sharing and its effects on HIV transmission
- High-risk sexual behaviors and their consequences
- AIDS prevention efforts targeted to adolescents
- Discussion of community policing and its role in prevention

- Mobilization of community prevention efforts -- for example, to counter advertising of alcohol in inner-city neighborhoods or to close crack houses
- Establishment of mentoring programs and recreation leagues for youth and provision of positive role models
- Self-esteem and its role in prevention
- Designated driver programs
- Parents and their roles in prevention
- Parenting skills training as a prevention tool.

CSAP has published numerous books, training guides, and curricula on prevention of AOD abuse, many of which would be suitable for use in training personnel in the AOD treatment and criminal justice systems and encouraging them to develop creative ways to prevent recidivism and reduce the offender population. A catalog that lists prevention materials available for use in training can be ordered from the National Clearinghouse for Alcohol and Drug Information (NCADI). (See phone numbers for NCADI on page v of this TIP.)

Confidentiality

Personnel in both systems need specific training in the Federal confidentiality regulations related to substance abuse and the protection of certain types of information about persons receiving treatment (42 U.S.C. §§290 dd-3 and ee-3 and 42 C.F.R. Part 2). These regulations should be thoroughly understood by staff who come into contact with the AOD-involved criminal offender. [Chapter 8](#) of this TIP provides detailed guidelines for operating treatment programs in compliance with these regulations. The chapter could be used as a training document or reference guide for staff.

Confidentiality regulations are sometimes interpreted by criminal justice officials and some AOD treatment providers as obstructions to getting needed information. However, most AOD treatment personnel consider confidentiality a key element of the treatment system because it builds clients' trust in the treatment process. Offenders, in particular, may have a great deal of fear about entering AOD treatment and may not consider treatment if they are not assured that their confidentiality will be protected.

Specific topics that could be addressed in training about confidentiality rules include

- The purpose of confidentiality regulations
- The general confidentiality rule ([see Chapter 8](#))
- Types of consent forms and their use
- Use of consent forms in interagency communications about the offender
- Exceptions to the general rule (for example, duty to warn others of threats, court-ordered disclosures, reports of child abuse and neglect).

Relapse Prevention

Personnel in the criminal justice system should be educated about the fact that relapse is a normal part of the addiction and recovery process. Consequently, strict requirements such as dismissal from the AOD treatment program on the basis of one or two positive urine samples are

not realistic but indicate the need for sanctions and for reassessment of the offender and the treatment plan. In 1993, CSAT published a Technical Assistance Publication on relapse, entitled *Relapse Prevention and the Substance-Abusing Criminal Offender*, which can be used in training staff from both systems. In addition to providing guidelines for staff, it describes specific Federal, State, and local relapse prevention programs that have operated successfully in correctional institutions and in the community.

Specific topics that should be addressed in the area of relapse prevention are

- Why offenders are especially vulnerable to relapse, including stressors related to release from the system and psychosocial factors related to crime and AOD use
- The recovery process and its various stages
- The unstabilized and stabilized relapse-prone individual
- "Stuck points" in recovery and how to get past them
- Basic principles of relapse prevention therapy, including self-knowledge and identification of warning signs, coping skills and management of warning signs, and involvement of significant others in the relapse prevention plan
- The timing of relapse prevention efforts, especially in advance of the release date.

Infectious Diseases

Initial and ongoing training must be provided about a range of communicable diseases, from the common cold to tuberculosis (TB) and sexually transmitted diseases (STDs) including HIV disease. Staff will benefit from understanding today's four major public health problems-- substance abuse, TB, HIV and acquired immunodeficiency syndrome (AIDS), and other STDs -- and from knowing that substance abuse is the common thread linking the other health problems.

Particular attention should be paid to training staff members about transmission of HIV disease so that fears and misunderstandings will not interfere with the provision of treatment.

Specific topics that might be included in staff training about medical issues are

- Transmission of HIV, TB, and STDs, including the role of unsafe behaviors
- Tests for HIV, TB, and STDs and what the test results mean
- Pre- and posttest counseling
- Medical information about HIV disease and AIDS, an overview of the stages of disease, and treatments for various complications
- HIV case management, including available primary care resources
- Recognizing the common manifestations of STDs (sores, rash, discharge)
- HIV/STDs and the law, including partner notification and confidentiality requirements.

Another TIP in this series, TIP 11: *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*, has an appendix that summarizes a curriculum developed by the Centers for Disease Control and Prevention (CDC) that has been used for the last 4 years to train outreach workers and HIV educators. The curriculum emphasizes prevention education.

CDC has prepared a variety of training and educational materials specific to TB, including a *Core Curriculum on Tuberculosis*, which contains material applicable to the correctional setting. A narrative text on *Tuberculosis in Correctional Facilities* is also available, with 67 accompanying slides, a videotape, and a wallchart on administering and interpreting the purified protein derivative (PPD) skin test for TB. *Doing Time With TB*, a brochure for inmates, contains five fact sheets covering exposure, the PPD skin test, TB prevention, treatment for TB, and the relationship between TB and HIV disease. CDC has also issued *Control of Tuberculosis in Correctional Facilities: A Guide for Health Care Workers*, which provides information on implementing CDC's guidelines on TB control and outlines recommended regimens of TB treatment.⁴

Cultural Competence

Cultural competence includes the behaviors, attitudes, and policies in a system or agency or among professionals that enhance effectiveness in cross-cultural situations. Cultural competence is based on understanding and respect for differences among people and groups. It is important to recognize that culture plays a complex role in peoples' lives and in the development of AOD use problems and their treatment.

Cultural competence is based on acceptance and respect for differences between people and groups. It is important to recognize that culture plays a complex role in peoples' lives and in the development of specific AOD use problems and their treatment.

Delivering culturally competent services is a basic tenet of AOD abuse treatment that must be presented and discussed in training for both AOD abuse providers and criminal justice personnel. Practical examples of cultural competence in program development and operation should be reviewed. Staff should be trained in cultural diversity and issues specific to the cultural populations that they serve. Topics to include in training might include

- Stereotypes and biases
- Language and terminology and their role in perpetuating stereotypes
- Diversity within groups (i.e., avoiding the belief that all members of a group are the same)
- Ethnic minority groups and their diverse heritages, especially as cultural beliefs relate to AOD use and criminal activity
- Women, including effects of AODs on women and stereotypes about women AOD abusers
- Gay men and lesbians, including effects of intolerance on treatment seeking.

Information should also be presented about people who are economically deprived, because they represent a majority of the offender population.

Two TIPs in this series present important information on providing culturally competent treatment. TIP 12: *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* has an appendix that describes a continuum of competence; it also contains a useful self-assessment tool, the Cultural Competence Checklist. The checklist can be used as the basis for a staff discussion of these issues. In addition, TIP 6: *Simple*

Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases reprints two articles in Appendix C that can be used in training sessions. In one forum-type article, a variety of treatment professionals discuss personal and professional experiences with prejudice and its effect on treatment. The other article describes a self-instructional comic-book-formatted guide that has been successfully used to prevent HIV infection among African American and Hispanic American adolescents.

Staff should receive specific training in cultural diversity and issues specific to the cultural populations that they serve.

Staff Issues

Persons working with AOD abusers in the criminal justice system experience high levels of stress, especially those who work directly with clients. Some staff may suffer from burnout or even posttraumatic stress disorder. Some personnel, particularly those working in correctional facilities, also may be victims of physical or verbal abuse. Frequently, there is little staff support when abusive situations occur. As a consequence of all of these issues, staff should receive training focused on burnout and handling stressful environments.

Specific topic areas might include

- Recognition of the signs of burnout in oneself and others
- How burnout affects significant others
- The role of peer support in preventing and dealing with burnout
- The importance of institutional policy and response to staff burnout
- Formation of groups within the institution to address sequelae of violent incidents, especially stress syndromes such as posttraumatic stress disorder
- How to deescalate or otherwise respond to potentially violent situations
- Stress management strategies, including relaxation techniques.

Summary

In summary, staff training needs can be immense. Currently, few staff members in either system are trained to use comprehensive and integrated approaches, to identify which approaches are appropriate for various situations and populations, and to use these approaches comfortably. For example, when working with clients who are fairly new to the criminal justice system and who do not have full-blown AOD abuse disorders, the staff should use approaches that differ from those used with offenders who have been in the criminal justice system for a long time. In the area of early intervention, staff training can help identify those at risk who may not exhibit robust signs and symptoms of AOD abuse or addiction. Staff can identify client life-style issues and behaviors associated with high risk for developing later AOD problems, even if the clients do not perceive these issues and behaviors as current concerns.

Endnote

1. Requests for CDC publications should be directed to the CDC's Information Service, 1600 Clifton Road N.E., Mailstop E-06, Atlanta, Georgia 30333; telephone (404) 639-1819.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Chapter 8 -- Confidentiality Issues [5](#)

Linking alcohol and other drug (AOD) abuse treatment with criminal justice sanctions involves legal and ethical issues that influence both the structure and operation of both systems.

Confidentiality is a primary concern, as is protection of the right to privacy. For example, how can program staff approach sources of information, such as families, employers, and other service providers, and at the same time protect the offender's right to privacy? Are there special rules when offenders are mandated into treatment as part of a criminal justice disposition? How can the many agencies responsible for the offender's welfare communicate with each other about the offender's assessment or treatment progress without violating the confidentiality rules? If the offender is threatening to harm him- or herself or another, can the treatment program notify criminal justice authorities? What rules apply to treatment programs housed in correctional facilities?

The five sections of this chapter that answer these questions are described below:

- An overview of the Federal law protecting the right to privacy of any person, including an offender, when that person is seeking or receiving AOD abuse assessment or treatment services is provided.
- There is detailed discussion of the rules surrounding the use of consent forms to get an offender's permission to release information about seeking or receiving AOD services, including the rule governing release of information to the criminal justice agency that mandated the offender into assessment or treatment.
- One section provides a review of the rules for communicating with others about the issues concerning an offender who is involved with AOD abuse assessment or treatment services. This review includes a discussion of communication among agencies, whether and how an AOD program may warn others of an offender's threats to harm, and how programs within correctional facilities can communicate with others in the facility and in the world outside.
- There is a discussion of other exceptions to the general rule that prevents disclosure of information about persons involved with AOD abuse assessment and treatment services, including regulations pertaining to the reporting of crimes on program premises or against program personnel.
- A few additional points are made concerning an offender's right to confidential services and the need for programs to obtain legal assistance.

Confidentiality requirements for adolescents are somewhat different than those for adults. A discussion of these issues is beyond the scope of this Treatment Improvement Protocol (TIP), which discusses adult offenders only. Readers interested in confidentiality issues for minors are referred to another TIP in this series, TIP 21: *Combining Alcohol and Other Drug Treatment Services With Diversion for Juveniles in the Justice System*.

Confidentiality

Federal Laws and the Right to Privacy

Two Federal laws and a set of regulations guarantee the strict confidentiality of information about persons -- including offenders -- receiving alcohol and drug abuse prevention, assessment, and treatment services. The legal citations for these laws and regulations are 42 U.S.C. §§290dd-3 and ee-3, and 42 C.F.R. Part 2.

These laws and regulations are designed to protect patients' privacy rights in order to attract people into treatment. The regulations restrict communications more tightly in many instances than, for example, either the doctor-patient or the attorney-client privilege. Violating the regulations is punishable by a fine of up to \$500 for a first offense and up to \$5,000 for each subsequent offense (42 C.F.R. Part 2 §2.4).

The Federal confidentiality laws and regulations protect any information about an offender if the offender has applied for or received any AOD abuse-related services from a program that is covered by the law. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or treatment referral. Restrictions on disclosure apply to any information that would identify the offender as an alcohol or drug abuser, either directly or by implication.

Some may view these Federal regulations, which protect privacy rights, as an irritation or a barrier to achieving program goals. However, most problems related to these regulations can easily be avoided by planning ahead. Familiarity with the regulations will ease communication and can reduce confidentiality-related conflicts among the treatment program, the client, and the criminal justice agency.

For an overview of Federal alcohol and other drug confidentiality laws, regulations, and options for successful communication and collaboration, see Lopez, 1994.

The General Rule

The Federal confidentiality laws and regulations protect any information about an offender if the offender has applied for or received any AOD abuse-related services from a program that is covered by the law. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or treatment referral. Restrictions on disclosure apply to any information that would identify the offender as an alcohol or drug abuser, either directly or by implication.⁶ The general rule applies from the time the offender makes an

appointment with the treatment program.⁷ It applies to offenders who are mandated into treatment as well as those who enter treatment voluntarily. It also applies to former clients or patients. The rule applies whether or not the person making an inquiry already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

What Types of Programs are Governed by the Regulations?

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for offenders with alcohol or other drug problems must comply with the Federal confidentiality regulations (42 C.F.R. Part 2 §212(e)). Although Federal regulations apply only to programs that receive Federal assistance, this assistance includes indirect forms of Federal aid such as tax-exempt status, or State or local government funding coming -- in whole or in part -- from the Federal Government. Thus, it can be seen that virtually all programs providing AOD services to offenders would be covered by these regulations, since funding for such services would come in whole or in part from Federal, State, or local government agencies.

Adherence to Federal regulations does not depend on how a program labels its services. A program that calls itself a "prevention program" or "assessment program" is not excused from adhering to the confidentiality rules. It is the kind of services, not the label, that determines whether the program must comply with the Federal law.

Adherence to Federal regulations does not depend on how a program labels its services. A program that calls itself a "prevention program" or "assessment program" is not excused from adhering to the confidentiality rules. It is the kind of services, not the label, that determines whether the program must comply with the Federal law.

When May Confidential Information Be Shared With Others?

Information protected by the Federal confidentiality regulations may be disclosed after the offender has signed a proper consent form. (If the offender is a minor, parental consent also must be obtained in some States.) The regulations also permit disclosure without the offender's consent in several situations, including medical emergencies, program evaluations, and communications among program staff.

The most commonly used exception to the general rule prohibiting disclosures is when a program obtains the offender's consent. The regulations provide two different forms of consent for mandated criminal justice clients. For communications between a program and the person or entity within the criminal justice system that mandated the offender's compliance with assessment or treatment, the program should use the special criminal justice system consent form (42 C.F.R. Part 2 §2.35; [Exhibit 8-1](#)). For all other consented disclosures, the program should use the general consent form authorized by the regulations (§2.31; [Exhibit 8-2](#)). The general consent form will be discussed first. The regulations' requirements regarding consent are somewhat unusual and strict and must be carefully followed.

Consent

Rules About Consent Forms

Most disclosures are permissible if an offender has signed a valid consent form that has not expired or been revoked (§2.31).⁸ Consent forms must be signed voluntarily; the offender is free to choose not to receive treatment.

A proper consent form must be in writing and must contain each of the items listed in §2.31:

- The name or general description of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the patient who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the patient may revoke the consent at any time, except to the extent that the program has already acted on it⁹
- The date, event, or condition upon which the consent expires, if not previously revoked
- The signature of the patient
- The date on which the consent is signed.

Information protected by the Federal confidentiality regulations may always be disclosed after the offender has signed a proper consent form. The most commonly used exception to the general rule prohibiting disclosures is for a program to obtain the offender's consent.

A general medical release form, or any consent form that does not contain all of the above elements, is not acceptable. (See sample consent form in [Exhibit 8-2](#).) A number of items on this list merit further explanation and are discussed in this chapter.

Purpose of Disclosure and Information Disclosed

The purpose of the disclosure and how much and what type of information are disclosed are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§2.13(a)). It would be improper to disclose everything in an offender's file if the recipient of the information needed only one piece of information.

In completing a consent form, it is important to determine the purpose or need for communicating the information. Once this need has been identified, it is easier to determine how much and what kind of information to disclose, providing only what is essential to accomplish the need or purpose that has been identified.

All disclosures, especially those made pursuant to a consent form, must be limited to information that is

necessary to accomplish the need or purpose for the disclosure.

For example, if an offender needs to document that he or she is in treatment in order to be eligible for a benefit program such as home relief, the purpose of the disclosure would be "to obtain home relief benefits," and the amount and kind of information to be disclosed would be "enrollment in treatment." The disclosure would then be limited to a statement that "Susan Martin [the offender/client] is participating in treatment at the XYZ Program." No other information about the offender would be released.

Offender's Right to Revoke Consent

The general consent form authorized by Federal regulations permits the offender to revoke consent at any time, and the consent form must include a statement to this effect. This is a key difference between the general consent form discussed here and the criminal justice system referral consent form presented below, which does not permit revocation. Revocation need not be in writing. However, if a program has made a disclosure prior to the revocation, the program has acted in reliance on the consent. In other words, the program was relying on the consent form when it made the disclosure. Therefore, the program is not required to try to retrieve the information it has already disclosed.

The regulations state that "acting in reliance" includes the provision of services while relying on the consent form to permit disclosures to a third-party payer. Third-party payers are health insurance companies, Medicaid, or any party that pays the bills other than the patient's family or the treatment agency. Thus, a program can bill the third-party payer for past services provided before the consent was revoked. However, a program that continues to provide services after a patient has revoked a consent authorizing disclosure to a third-party payer does so at its own financial risk.

Expiration of Consent Form

The form must also contain a date, event, or condition upon which consent will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (42 C.F.R. Part 2 §2.31(a)(9)). If the purpose of the disclosure can be expected to be accomplished in 5 or 10 days, it is better to fill in that amount of time rather than a longer period, or to have all consent forms uniformly expire in 60 or 90 days.

The consent form does not need to contain a specific expiration date, but it may instead specify an event or condition. For example, if an offender has been placed on probation at school or work on the condition that she or he attend counseling at the program, a consent form should be used that does not expire until the completion of the probation period. Or, if an offender is being referred to a specialist for a single appointment, the consent form should provide that it will expire within a reasonable time after he or she has seen the specialist, allowing the AOD treatment provider and the specialist time to communicate after the appointment.

Required Notice Against Redisclosing Information

Once a consent form has been properly completed, one last formal requirement remains. Any disclosure made with written patient consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient at the time of disclosure, or earlier. ([See Exhibit 8-3.](#))

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. Of course, an offender may sign a consent form authorizing such a redisclosure.

Note on the Use of Consent Forms

The fact that an offender has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b); 2.61(a)(b)). The program's only obligation is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid (§2.31(c)).

In most cases, the decision of whether or not to make a disclosure pursuant to a consent form is within the discretion of the program, unless State law requires or prohibits disclosure once consent is given. In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose of the communication.

Special Rules About Consent Forms

Programs assessing and treating offenders must follow the confidentiality rules that generally apply to drug and alcohol programs. However, some special rules apply when an offender comes for assessment or treatment as an official condition of probation, sentencing, dismissal of charges, release from detention, or other disposition of any criminal proceeding; and information is being disclosed to the mandating agency.

A consent form or court order is still required before any disclosure can be made about an offender who is mandated into assessment or treatment. However, the rules concerning the length of time that a consent remains valid are different. A "criminal justice system consent" cannot be revoked before its expiration event or date. Specifically, the regulations require that the following factors be considered in determining how long a criminal justice system consent will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding in which the offender is involved
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur
- Other information the patient, program, or criminal justice agency believes is relevant.

These rules allow programs to continue to use a traditional expiration condition for a consent form that once was the only one allowed: "when there is a substantial change in the patient's justice system status." This formula appears to work well. A substantial change in status occurs whenever the offender moves from one phase of the criminal justice system to the next. For example, if an offender is on probation or parole and is in a program as a condition of probation or parole, there would be a change in criminal justice status when the term of probation or parole ended, either by successful completion or revocation. Thus, the program could provide an assessment or periodic treatment reports to the probation or parole officer monitoring the offender and could even testify at a probation or parole revocation hearing if it is so desired, since no change in criminal justice status would occur until after that hearing.

In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose of the communication.

As for the revocability of the consent -- the rules under which the offender can take back his or her consent -- the regulations provide that the consent form can state that consent cannot be revoked until a certain specified date or condition occurs. The regulations permit the criminal justice system consent form to be irrevocable so that an offender who has agreed to enter treatment in lieu of prosecution or punishment cannot prevent the court, probation department, or other agency from monitoring his or her progress. Note that although a criminal justice system consent may be made irrevocable for a specified period of time, its irrevocability must end no later than the final disposition of the criminal proceeding. Thereafter, the offender may freely revoke consent. ([See Exhibit 8-1.](#))¹⁰

Several other considerations relating to criminal justice system referrals are important. First, any information received by one of the eligible criminal justice agencies from a treatment program can be used by that justice agency only in connection with its official duties with respect to that particular criminal proceeding. The information may not be used in other proceedings, for other purposes, or with respect to other individuals (42 C.F.R. Part 2 §2.34(d)). Second, whenever possible, it is best to have the judge or referring agency require that a proper criminal justice system consent form be signed by the offender before he or she is referred to the treatment program. If that is not possible, the treatment program should have the offender sign a criminal justice system consent form at his or her very first appointment. With a proper criminal justice consent form signed, the AOD abuse treatment program can communicate with the referring criminal justice agency even if the offender appears for assessment or treatment only once. This procedure avoids the unfortunate problems that may arise if an offender mandated into assessment or treatment does not sign a proper consent form and then leaves before the assessment or treatment has been completed.

If a program fails to have the offender sign a criminal justice system form and the offender fails to complete the assessment process or treatment, the program has few options when faced with a request for information from the referring criminal justice agency. The program could attempt to locate the offender and ask him or her to sign a consent form, but that, of course, is unlikely to happen. Also, there is some question of whether a court can issue an order to authorize the program to release information about a referred offender who has left the program in this

situation. This question comes up because the regulations allow a court to order disclosure of treatment information for the purpose of investigating or prosecuting a patient for a crime only when the crime is "extremely serious," and a parole or probation violation generally will not meet that criterion. Therefore, unless a consent form is obtained by the judge or criminal justice agency or by the treatment program at the very beginning of the assessment or treatment process, the program may ultimately be prevented from providing any information to the criminal justice agency that referred the offender.

If the offender referred by a criminal justice agency never applies for or receives program services, that fact may be communicated to the referring agency without patient consent (42 C.F.R. Part 2 §2.13(c)(2)). But once an offender makes an appointment to visit the program, consent or a court order is needed for any disclosures.

Whenever possible, it is best to have the judge or referring agency require that a proper criminal justice system consent form be signed by the offender before referral to treatment.

Communicating With Others

Given these rules regarding consent, consider the questions introduced at the beginning of this chapter: How can programs seek information from collateral sources about offenders they are assessing? How can the many diverse criminal justice and treatment agencies effectively communicate without violating the Federal rules? What rules apply to treatment programs that are housed in a correctional facility? Do programs have a duty to warn others of threats by offenders, and if so, how do they communicate the warning?

Seeking Information from Collateral Sources

Making inquiries of employers, schools, doctors, and other healthcare entities might, at first glance, seem to pose no risk to an offender's right to confidentiality. But it does.

When a program that screens, assesses, or treats offenders asks an employer, doctor, family member, AOD program that previously treated the offender, or mental health professional to verify information it has obtained from the offender, the program is making a patient-identifying disclosure that the offender has sought its services. In other words, when program staff seek information from other sources, they are informing these sources that the offender has asked for AOD services. Federal regulations generally prohibit this kind of disclosure unless the offender consents.

How, then, is a screening or assessment program to proceed? The easiest way is to get the offender's consent to contact the employer, family member, school, AOD abuse treatment program, healthcare facility, and the like. As noted above, when filling out the consent form, thought should be given to the purpose of the disclosure and how much and what kind of information would be disclosed. For example, if a program is assessing an offender for treatment and seeks records from a mental health provider, the purpose of the disclosure would be "to obtain mental health treatment records to complete the assessment." The kind of information

disclosed would then be limited to a statement that "Michael Smith [the offender] is being assessed by the XYZ Program." No other information about Michael Smith would be released to the mental health provider.

If the program not only seeks records, but also needs to discuss with the mental health provider the treatment it provided the offender, the purpose of the disclosure would be "to discuss mental health treatment provided to Michael Smith by the mental health program." If the program merely seeks information, the kind of information disclosed would, as in the example above, be limited to a statement that "Michael Smith [the offender] is being assessed by the XYZ Program." However, if the program needs to disclose information it gained in its assessment of Michael Smith to the mental health provider in order to further the discussion, the kind of information disclosed would be "assessment information about Michael Smith."

A program that routinely seeks collateral information from many sources could consider asking the offender to sign a consent form that permitted disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or the name of the organization" for each collateral source the program may contact. Whichever method the program chooses, it must use the general consent form, not the special criminal justice system consent form.

Programs should keep in mind that even when information is disclosed over the telephone, they are still required to notify those receiving the information of the prohibition on redisclosure. Mention should be made of this restriction during the conversation; for example, program staff could say, "I'll be sending you a written statement that the information I gave you about Mr. Smith cannot be redisclosed."

Ongoing Communication

Communicating With the Referring Criminal Justice Agency

Programs performing offender assessments mandated to AOD services must be able to communicate with the referring criminal justice agency for a span of time long enough to perform the assessment, write a report, and make a presentation to the court or agency. Programs performing assessments should have the offender sign a criminal justice system consent form that expires after the offender's next change in criminal justice status. For example, suppose the offender has been convicted of a crime and has not yet been sentenced but is being considered for probation. The program performing the assessment (Program A) should make sure that the offender signs a criminal justice system consent form that expires after the offender's sentencing. In that way, Program A is assured of being able to continue communicating with the agency that referred the offender -- whether it was the court or the probation department -- until a final decision has been reached.

Programs providing treatment should be able to communicate with the referring criminal justice agency over an extended period of time. Therefore, the agency to which the offender is assigned for his or her mandated treatment, Program B, should have the offender sign a criminal justice

system consent form permitting communication with the referring criminal justice agency until the period of probation or parole is completed -- either successfully or through revocation proceedings.

Communication Between AOD Programs

Suppose that the agency into which the offender has been placed for treatment (Program B) wants to see the assessment that was done by a different program (Program A). How can Program B get a copy? The assessment report prepared by Program A may well be a part of the offender's criminal justice record maintained by the probation department. But it is still protected by the Federal regulations and cannot be released to Program B or anyone else without the offender's consent. If Program B needs the assessment report prepared by Program A, it should have the offender sign two consent forms: one permitting it to ask Program A for the report -- since Program A has now become a collateral source -- and another permitting Program A to release the report to Program B.

As noted above, Program B must also have the offender sign a criminal justice system consent form permitting Program B to have ongoing communication with the criminal justice agency that mandated the offender into treatment. All other communications by Program B with the outside world, including other criminal justice agencies, must be dealt with on an individual basis, either by consent or by ensuring that the proposed disclosure falls within one of the other narrow exceptions permitted by the Federal regulations.

These same issues must be considered whenever an offender's treatment provider changes. For example, suppose an offender is treated for AOD abuse in a community-based treatment program as part of probation or parole, and probation or parole is subsequently revoked, resulting in incarceration. An AOD assessment or treatment program in a correctional facility can obtain the AOD treatment records that were compiled by a community-based AOD abuse treatment program during the offender's probation or parole, but only after obtaining the offender's consent to do so. Similarly, when an offender is in treatment for AOD abuse in a jail or prison and is then referred for continuing care in a community-based program, the treatment record compiled by the correctional facility can be released to the community-based program only with the offender's consent.

Special Problems of AOD Treatment Programs Housed in Correctional Facilities

AOD programs housed in correctional facilities, and AOD programs that are in correctional facilities dedicated to AOD treatment, face special problems in complying with the Federal confidentiality regulations. Free-standing community-based programs must think through every disclosure they make about offenders, but they are able to perform many of their basic functions without making any disclosures. Programs housed in correctional institutions, unlike community-based programs, would be unable to function without being able to communicate at least some information to the security staff at the institution, to the corrections department, and to other parts of the criminal justice system.

To take an obvious example, an AOD treatment program in a maximum-security correctional facility would be required to provide the security staff with a "count" of inmates regularly during the day. A statement that "150 inmates are in the unit" violates no one's confidentiality, but if one inmate has disappeared, the AOD program clearly must report his or her name to the security staff. (See the subsequent discussion of "Communications That Do Not Disclose Patient-Identifying Information." This disclosure that an inmate named Arthur Greenfield was missing from the AOD program would be a disclosure prohibited under the Federal regulations, even though the security staff knew full well that Arthur was in the program. How can the program proceed? Must it get Arthur's consent to disclose his disappearance? Not necessarily. The regulations permit staff within a program to make certain disclosures to each other and to those with direct administrative control over the program:

The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (42 C.F.R. Part 2 §2.12(c)(3)).

In other words, staff who have access to offender AOD records because they work for the program, including full- or part-time employees and unpaid volunteers, may consult among themselves or otherwise share information if their substance abuse work so requires. And staff may communicate patient-identifying information to a person or entity having "direct administrative control" over a program if there is a need for the information "in connection with their [AOD] duties." The question is whether the above example fits within this exception. This is not an easy question. However, the argument can be made that the AOD program housed in a correctional facility cannot function unless it can engage in this kind of communication, and therefore the communication is "in connection with [its AOD] duties."

How far this exception can be expanded is an open question. Can the AOD abuse treatment program communicate patient-identifying information to the central office of the Department of Correction? If the Department of Correction has jurisdiction not only over correctional facilities but also over probation and parole, can information be shared as the offender moves from probation to an institution or from an institution to parole?

The answers to these kinds of questions are among the most complicated in this area. In brief, there may be circumstances in which the AOD treatment unit can share information with other units or a supervisory agency without the offender's consent, but it is essential before such a system is set up that an expert in the area be consulted for assistance.

Two crucial issues must be considered. First, the program must always keep in mind that it may communicate only information that will assist it or the supervisory entity to provide AOD services.

The second issue to consider is that once communications are made to an entity having administrative control over the program, that entity becomes part of "the program," and it is now subject to the Federal confidentiality regulations. This transition means that personnel in that

entity must become familiar with the Federal rules and that information from the AOD program cannot be redisclosed to anyone else unless the inmate consents or one of the other exceptions in the Federal regulations applies.

In the example given above about the prisoner's escape, the warden or security staff could call the police to report an escape from the facility because disclosure of Arthur's disappearance need not reveal any patient-identifying information. The warden need only report that a prisoner named Arthur Greenfield has escaped; there is no need to report that the prisoner was in the AOD program. But in other circumstances, disclosure might be prohibited. (See subsequent discussion of "Communications That Do Not Disclose Patient-Identifying Information.")

AOD programs that are in correctional facilities dedicated to AOD treatment present even more difficult confidentiality issues. Strictly interpreted, the Federal regulations prohibit the warden of a dedicated correctional facility from acknowledging to anyone that Arthur is an inmate because that would disclose Arthur's AOD abuse problem. While §2.12(c)(3) might permit the warden to make some kinds of disclosures to the Department of Correction, since the Department has direct administrative control over the institution, the warden might not be permitted to acknowledge Arthur's presence, for example, to a sheriff who came to serve Arthur with legal papers, or to his wife who came to visit, unless Arthur had signed a proper consent form agreeing to have the fact of his treatment disclosed to his wife or to the sheriff.

One solution to this problem is to have the offender, upon entering treatment at a dedicated correctional facility, sign consent forms that would permit the warden to disclose information in the event the offender escaped or otherwise misbehaved¹¹ in a way that required communication with the outside world. While the offender could revoke these consent forms, it is unlikely that he or she would remember to do so before a report were made.

Jurisdictions that consider establishing a system of comprehensive treatment for offenders along the entire criminal justice continuum and would like to encourage a flow of information about those offenders in treatment should settle confidentiality questions before the system is established. Planners may find that the most sensible way to deal with questions about how protected information can flow from arrest through incarceration through parole and back is to use consent forms. As the offender enters each phase of the system, a series of signed consent forms will enable the treatment program to

- Gain information from AOD programs in the system that previously treated the offender
- Communicate with those criminal justice entities with whom communication is essential
- Disclose information to AOD abuse treatment programs that will treat the offender in the next phase of supervision.

Offenders who refuse to sign consent forms permitting essential communications can be excluded from treatment and returned to the general population or provided treatment temporarily in the hope that resistance to signing the consent forms will lessen as treatment proceeds.

A sensible way to deal with questions about how protected information can flow from arrest through
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incarceration through parole and back is to use consent forms.

Duty to Warn

For most treatment professionals, the issue of reporting a patient's threat to harm someone or to commit a crime is troubling. Many professionals believe that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly when the crime is a serious one.

There has been a developing legal trend to require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn a potential victim when his patient threatened to kill, and then the patient killed the threatened individual. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

While the *Tarasoff* ruling, strictly speaking, applies only in California, courts in a number of other States have followed *Tarasoff* in finding therapists liable for money damages when they failed to warn someone threatened by a patient. Most of these cases are limited to situations in which patients threaten a specific, identifiable victim, and they do not usually apply when a patient makes a general threat without identifying the intended target. States that have enacted laws on the subject have similarly limited the duty to warn to such situations.

When a program is faced with a question about duty to warn, there are always at least two and sometimes three questions that must be answered:

1. Is there a legal duty to warn in this particular situation under State law?
2. Even if there is no State legal requirement that the program warn an intended victim or the police, does the program feel a moral obligation to warn someone?

The first question can only be answered by an attorney familiar with the law in the State in which the program operates. If the answer to the first question is "no," it is advisable to discuss the second question with a knowledgeable lawyer also.

3. If the answer to questions 1 or 2 is "yes," can the program warn the victim or someone likely to be able to take action without violating the Federal AOD confidentiality regulations?

The problem is that there is a conflict between the Federal confidentiality requirements and the "duty to warn" imposed by States that have adopted the principles of the *Tarasoff* case. Simply put, the Federal confidentiality law and regulations prohibit the type of disclosure that *Tarasoff*

and similar cases require,¹² unless the program can make the disclosure by using one of the regulation's narrow exceptions.

There are five ways a program can proceed when an offender makes a threat to harm him- or herself or another person, and the program decides to report the threat. First, the program can make a report to the criminal justice agency that mandated the offender into treatment, as long as it has a criminal justice system consent form signed by the offender that is worded broadly enough to allow this sort of information to be disclosed. The criminal justice agency can then act on the information. However, the regulations limit what the criminal justice agency can do with the information. Anyone receiving information pursuant to a criminal justice system consent "may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given" (42 C.F.R. Part 2 §235(d)).

Thus, the disclosure can be used by the referring criminal justice agency to revoke an offender's conditional release, probation, or parole. If the referring criminal justice agency wants to warn the victim or to notify another law enforcement agency of the threat, it must be careful that no mention is made that the source was an AOD program or that the offender is in AOD assessment or treatment. (Disclosures that do not identify the offender as someone with an AOD problem are permitted. See the discussion of this exception below.) However, the disclosure most likely cannot be used to prosecute the offender for a separate crime (in other words, for making the threat). The only way to prosecute an offender based on information obtained from a program is to obtain a special court order in accordance with 42 C.F.R. Part 2 §2.65. (See below.)

The second way a program can proceed when an offender makes a threat to harm him- or herself or another person is to request a court order authorizing the disclosure. The program must take care that the court abides by the requirements of the Federal AOD regulations. (See the discussion of the court order exception below.)

A third way to proceed is to make a disclosure that does not identify as a patient the individual who threatens to commit the crime. This nondisclosure can be accomplished either by making an anonymous report or, for a program that is part of a larger non-AOD entity, by making the report in the larger entity's name. For example, a counselor employed by an AOD program that is part of a mental health facility could phone the police or the potential target of an attack, identify him- or herself as "a counselor at the New City Mental Health Clinic," and explain the risk to the potential target. This mode of reporting would convey the vital information without identifying the client as an AOD abuser. Counselors at free-standing AOD units cannot give the name of the program.

A fourth way to proceed is to make a report to medical personnel if the threat presents a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical intervention (§2.51). (See the discussion of the medical emergency exception later in this chapter.)

Finally, the program can obtain the client's consent to report the threat of harm to the individual he or she has threatened.¹³

If none of these five options is practical, what should a program do when confronted with conflicting moral and legal obligations? If a program believes there is a clear and imminent danger to a client or a particular person, it is probably wiser to err on the side of making an effective report about the danger to the authorities or to the threatened individual. This is especially true in States that already follow the Tarasoff rule.

While each case presents different questions, it is doubtful that any prosecution or successful civil lawsuit under the confidentiality regulations would be brought against a counselor who warned about potential violence when he or she believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the counselor should at least try to make the warning in a manner that does not identify the individual as an alcohol or other drug abuser.

While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a counselor who warned about potential violence when he or she believed in good faith that there was real danger to a particular individual.

Seven Exceptions to the General Rule

Reference has been made to other exceptions of the Federal confidentiality rules to the general rule prohibiting disclosure regarding offenders who are assessed or treated for AOD abuse. Seven exceptions to the general rule are described below.

Communications That Do Not Disclose Patient-Identifying Information

The Federal regulations permit programs to disclose information about an offender if the program reveals no patient-identifying information. "Patient-identifying" information is information that identifies someone as an alcohol or other drug abuser. Thus, a program may disclose information about an offender if that information does not identify him or her as an AOD abuser or support anyone else's identification of the offender as an AOD abuser.

There are two basic ways a program may make a disclosure that does not identify a patient. The first way is obvious; a program can report aggregate data about its population -- summary information that gives an overview of the patients served in the program -- or some portion of its populations. Thus, a program could tell the newspaper that in the past 6 months it screened 43 offenders, 10 female and 33 male. Using the second method, a program can communicate information about an offender in a way that does not reveal the offender's status as a drug or alcohol abuse patient (42 C.F.R. Part 2 §2.12(a)(i)). For example, a program that provides services to clients with other problems or illnesses as well as alcohol or other drug abuse may disclose information about a particular client as long as the fact that the client has a substance abuse problem is not revealed. Specifically, a program that was part of a general hospital could have a counselor call the police about a threat a client made, as long as the counselor did not

disclose that the client had an AOD abuse problem or was a client of the AOD abuse treatment program.

Programs that provide only alcohol or other drug services or that provide a full range of services but are identified by the general public as AOD treatment programs cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "XYZ Treatment Program" will automatically identify the offender as someone in the program. However, a free-standing program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the offender's status as an alcohol or other drug abuser.

Court-Ordered Disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about an offender that would otherwise be forbidden. A court may issue one of these authorizing orders only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant or arrest warrant, even when signed by a judge, is not alone sufficient to require or even to permit a program to disclose information (§2.61).¹⁴

A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient to require or even to permit a program to disclose information.

Before a court can issue a court order authorizing a disclosure about an offender, the program and any offenders whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court.¹⁵ Generally, the application and any court order must use fictitious names for any known offender, and all court proceedings in connection with the application must remain confidential unless the offender requests otherwise (§§2.64(a), (b); 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure would have on the patient, or the doctor-patient or counselor-patient relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)). The judge may examine the records before making a decision (§2.64(c)).

If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a patient for a crime, the court must also find that

- The crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury
- The records sought are likely to contain information of significance to the investigation or prosecution

- There is no other practical way to obtain the information
- The public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, and the ability of the program to provide services to other patients.

When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. (If the program is a governmental entity, it must be represented by counsel, §2.65(d)). There are also limits on the scope of the disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the offender's confidentiality, including sealing court records from public scrutiny (§§2.64(e); 2.65(e)).

The court may order disclosure of "confidential communications" by an offender to the program only if the disclosure

- Is necessary to protect against a threat of death or serious bodily injury
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Is in connection with a proceeding at which the offender has already presented evidence concerning confidential communications (for example, "I told my counselor . . .") (§2.63).

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about [an offender] for the purpose of treating a condition which poses an immediate threat to the health" of the offender or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51). The medical emergency exception permits disclosure only to medical personnel. This restriction means that this exception cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including family.

Whenever a disclosure is made to cope with a medical emergency, the program must document in the offender's records

- The name and affiliation of the recipient of the information
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency.

Crimes on Program Premises or Against Personnel

When an offender has committed or has threatened to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the suspect's

name, address, last known whereabouts, and status as a patient at the program (42 C.F.R. Part 2 §2.12(c)(5)).

Sharing Information With an Outside Agency (QSOAs)

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a qualified service organization agreement (QSOA).

A QSOA is a written agreement between a program and a person providing services to the program. In the QSOA, the person 1) acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the program he or she is fully bound by Federal confidentiality regulations; and 2) promises that, if necessary, he or she will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations (§§2.11; 2.12(c)(4)). A sample QSOA is provided in [Exhibit 8-4](#).

A QSOA should only be used when an agency or official outside the program is providing a service to the program itself. An example is when laboratory analysis or data processing is performed for the program by an outside agency. A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so the program can function effectively. QSOAs may not be used between programs providing alcohol and other drug services.

Reporting Child Abuse and Neglect

All 50 States and the District of Columbia have statutes that require reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral -- usually telephone -- report, and many now have toll-free numbers to facilitate reporting. Half the States require that both oral and written reports be made. All States extend immunity from prosecution to persons reporting child abuse and neglect. In other words, a person who reports child abuse or neglect cannot be brought into court. Most States provide penalties for failure to report.

The Federal confidentiality regulations permit programs to comply with State laws that require reporting child abuse and neglect. Thus, if an offender reveals to program staff that he or she has neglected or abused children, that fact may well have to be reported to State authorities. Note, however, that this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information or even subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the offender consents or the appropriate court issues an order under subpart E of 42

C.F.R. Part 2. Because of the variation in State laws, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance.

Research, Audit, or Evaluation

Confidentiality regulations also permit programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, providing certain safeguards are met (§§2.52; 2.53). Another TIP in this series, TIP 14: *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*, addresses these issues.

All 50 States and the District of Columbia have statutes that require reporting when there is reasonable cause to believe or suspect child abuse or neglect. Most States now require both physicians and educators as well as social service workers to report child abuse.

Other Confidentiality Rules

Patient Notice and Access to Records

Federal confidentiality regulations require programs to notify patients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to offenders when they begin participating in the program or soon thereafter (§2.22(a)). The regulations also contain a sample notice. Programs can use their own judgment to decide when to permit offenders to view or obtain copies of their records, unless State law grants patients the right of access to records. The Federal regulations do not require programs to obtain written consent from patients before permitting them to see their own records.

Security of Records

Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe, or other similar container. (Staff in correctional facilities may face special problems maintaining records in accordance with the regulations. However, procedures must be worked out that follow the regulations as closely as possible.) The program should establish written procedures that regulate access to and use of offenders' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§2.16).

A Final Note

Drug and alcohol treatment programs should use the services of a lawyer familiar with local laws affecting their programs. As mentioned previously, State law governs many issues related to assessing and treating offenders. A local practitioner is the best source for advice on such subjects. Moreover, when it comes to certain issues, the law is still developing. For example, programs' "duty to warn" of clients' threats to harm others is constantly changing as courts in

different States consider cases brought against a variety of different kinds of care providers. Programs trying to decide how to handle such a situation need up-to-the minute advice on their legal responsibilities.

Endnotes

- 1. This chapter was written for the consensus panel by Margaret K. Brooks, Esq.
- 2. The results of urine tests performed by AOD programs are protected by the Federal regulations. However, testing conducted by criminal justice authorities or correctional facilities for the purpose of uncovering illegal drug use or monitoring offenders' (or inmates') compliance with rules against illegal drug use are not protected under the Federal regulations.
- 3. Only offenders who have "applied for or received" services from a program are protected. If an offender has not yet been assessed or counseled by a program and has not him- or herself sought help from the program, the program is free to discuss the offender's drug or alcohol problems with others. But from the time the offender applies for services, or the program first conducts an assessment or begins to counsel the offender, the Federal regulations govern.
- 4. Note, however, that no information that is obtained from a program (even if the patient consents) may be used in a criminal investigation or the prosecution of a patient unless a court order has been issued under the special circumstances set forth in 42 C.F.R. Part 2 §2.65; see also §2.12(a), (d); 42 U.S.C. §290 dd3(c).
- 5. For a discussion of the different rules governing consent when the offender is mandated into treatment as part of a criminal justice sanction, see "Special Rules About Consent Forms" later in this chapter.
- 6. Once the criminal justice system consent has expired, no further information can be disclosed -- unless the offender signs another (noncriminal justice system) consent to release the information, or another of the regulations' exceptions applies. For a discussion of how an AOD assessment or treatment program in a correctional facility can obtain the AOD treatment records that were compiled by a community-based AOD treatment program during the offender's probation or parole, see subsequent text.
- 7. An escape and some other kinds of misbehavior may be criminal acts. These can be reported to law enforcement authorities because they are crimes on program premises or against program personnel. See subsequent discussion of this exception.
- 8. Moreover, the Federal AOD regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§2.20). As of this writing, the only case that addresses this conflict between Federal and State law is *Hasenie v. United States*, 541 F. Supp. 999 (D. Md. 1982), in which the court ruled that the Federal confidentiality law prohibited any report.
- 9. Note that the Federal statutes and regulations strictly prohibit any investigation or prosecution of a client based on information obtained from records, unless the court order exception was used. 42 U.S.C. §290 dd-3(c) and ee-3(c) and 42 C.F.R. Part 2 §2.12(d)(1).
- 10. For an explanation of how to deal with subpoenas and search and arrest warrants, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1991 by the Legal Action Center, 153 Waverly Place, New York, New York 10014.
- 11. However, if the information is being sought to investigate or prosecute a patient for a crime, only the program need be notified (§2.65). And if the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series

17

Chapter 9 -- Evaluation ¹⁶

Alcohol and other drug (AOD) treatment programs for offenders are designed to achieve certain goals, such as reduced AOD use, decreased criminal activity, and increased employment. Programs may also attempt to improve psychological status or family relationships, or to reduce emergency room use. Evaluation can be used to assess the attainment of these goals. Evaluation can also help identify problems with implementing programs and program components that are ineffective or need modification. In this chapter, evaluation refers to the use of research methods to measure the extent to which a program achieves its goals or produces certain other effects.

Evaluation studies are used to assess programs and examine their effectiveness before large amounts of time, money, and other resources are invested. ([Chapter 2](#) reviews several studies of the effectiveness of AOD treatment in the criminal justice system.) Programs that prove to be ineffective or marginally effective can be examined more closely and modified to enhance their effectiveness. Even a highly successful program can benefit from an examination of the components that contribute to positive outcomes in order to eliminate the components that have no impact, to document a theoretical base, and to provide information for use in replication ([Rossi, 1987](#)).

Purpose of Evaluation

Program evaluations serve a practical rather than a theoretical purpose -- to collect reliable evidence that can be used to persuade key decisionmakers to commit financial and other resources. Those decisionmakers might include legislators, agency administrators, and foundation directors. Thus, program evaluation provides one source of input for policymakers to use in the decision process. It is important to note that a direct relationship exists between the persuasive power of requests for funding based on program effectiveness and the strength and integrity of the program's evaluation study. A program with strong evaluation results is likely to receive a better hearing and to have a higher chance of continued or increased funding than a program with no outcome results. However, reality has shown that policymakers come to decisions based on the best available evidence, which in some cases may be quite limited and poorly founded.

Evaluations examine program implementation and operation (process evaluation) and program outcomes (outcomes evaluation). This chapter addresses process evaluation to a limited degree;

it primarily focuses on selected issues related to evaluating the outcomes of criminal justice treatment programs, and it includes summaries of the results of several outcomes studies.

It is important to note that programs should be designed so that an evaluation component is built in from the outset and is an ongoing aspect of the program's operation. The types of data gathered and the manner in which they are stored should facilitate the evaluation function. When new program elements are introduced, ways to evaluate their effectiveness should play a strong role in their implementation.

A separate Treatment Improvement Protocol (TIP) in this series, TIP 14: *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*, describes the evaluation process and addresses the many variables that should be addressed in well-designed studies.

Process Evaluation

Process evaluation is useful in examining the implementation procedures and operation of a treatment program in comparison with the program's stated intent. Process evaluation can be used to determine whether subjects actually received the intervention as it was intended to be delivered. Process evaluation also can be used to measure the intensity and duration of the services provided. Unless the evaluation describes what happens during treatment, program strengths will not be described and changes in program design will not be made.

Numerous treatment efforts have been ineffectual, misunderstood, or misinterpreted because what was actually implemented was not what was described in the original program design. Process evaluation can be used to assess whether the program that was originally designed is the program that is being tested. In addition, process evaluation can help interpret the results of an outcome evaluation. Process evaluation provides an assessment of the program's strengths and weaknesses and can indicate ways in which a program can be improved, serving as a management tool for program development.

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Outcomes Evaluation

Outcomes evaluation is designed to determine the effectiveness of an intervention as compared with a control (no treatment) group, an alternative intervention, or a standard intervention. It measures and assesses a program's effect; that is, the ability of a program to produce changes of the specified type and desired direction in the people who are exposed to it.

Ideally, the evaluation should be conducted by an external person or group to avoid bias in data collection and analysis. However, many institutions and programs conduct their own evaluations and such evaluations can be very useful.

Program evaluation can provide answers to a number of questions. Did the treatment group show significant change in relation to the comparison group, and can that change be attributed to the intervention? How well does the program work in real-world settings? With which subgroups does it work? What kinds of effects can be expected from the program and at what magnitude? What are the essential ingredients of the program? Obtaining answers to each of these questions requires changing the research strategy. Thus, a program evaluator must have a clear idea about the purpose of the evaluation to develop the appropriate evaluation design.

Evaluation Issues

A number of problems can occur when implementing outcomes evaluation studies. These problems can call the validity of the evaluation results into question. The occurrence of one or more of the following problems makes it difficult to determine what is being evaluated, whether the results are valid, or whether the results can be applied to the intended population ([Dennis, 1993](#)):

- Variations in the delivery of treatment such as unplanned alterations in the amount of counseling received by clients.
- Contamination of the evaluation design; for instance, knowledge or resources that are intended only for the treatment group also are received by the comparison group.
- Too few subjects are included in the study, a fact that may not be known until after the evaluation has begun.
- Compromise of the random assignment procedure; for example, parole officers should not assign clients to the randomly selected group.
- Changes in the environment within which the evaluation takes place; for instance, new State regulations may require modification in the treatment protocol.
- Changes that occur in the intervention over time such as staff turnover.

The presence of any of these problems can lead to questions about the validity of the evaluation results. To the extent possible, the program evaluator should take steps before the study commences to reduce the likelihood that these problems will occur. For instance, written protocols and careful documentation make for greater uniformity and delivery of services. Or, a pilot study to examine the flow of clients with the targeted characteristics through a probation department could ensure the availability of an adequate number of study subjects. The implementation also should be carefully monitored to preserve the integrity of the research design. If deviations occur, they should be documented and reported in the final study report.

Sample Size

One issue of particular importance to assessing the effectiveness of treatment programs is sample size. The smaller the sample size, the lower the probability of detecting statistically significant treatment effects. This aspect of the research design, known as power analysis, is often

overlooked, but it is important because program evaluations with sample sizes that are not large enough to detect treatment effects can waste resources and may lead to abandoning otherwise promising treatment approaches.

The "nothing works" doctrine in the criminal justice field is partly attributable to research studies with small samples that failed to give rehabilitation programs a chance to prove themselves. To correct this problem, the evaluator should determine a sample size that is large enough to show whether the intervention makes a difference in the population and to conclude whether the treatment program did produce an effect. The technical procedure for doing this is beyond the scope of this chapter but can be found in a number of standard texts ([Cohen, 1977](#); [Lipsey, 1990](#)).

Successful program implementation and management depends on more than a good design and an adequate number of subjects. It also relies on the cooperation of staff and others involved in the intervention. This cooperation can be expected in a research environment. But in "real-world" settings like prisons, jails, probation departments, and community treatment programs, the intervention can place demands on people that they initially may be unwilling to assume. If staff members are not convinced of the need for the study, they can actively undermine the evaluation procedures.

An evaluator may use a number of strategies to gain and maintain the cooperation of program staff ([Dennis, 1993](#)), including

- Explaining to staff the purpose of the study and how the results will be used
- Sharing the draft instruments and the study procedures with staff for their review and feedback
- Taking staff concerns about the study seriously and making accommodations that do not compromise the study's integrity
- Providing staff with periodic feedback on the study's progress and preliminary findings
- Being aware of the time schedule and program deadlines and attempting to minimize conflicts between program activities and study procedures.

Research Followup

Similar considerations apply to gaining a subject's cooperation. Methods must be developed to reduce study attrition, from which every study suffers. The longer the study, the greater the number of subjects who drop out. Attrition can bias the results and, in the worst case, defeat the study.

Researchers have developed a number of techniques ([Dennis, 1993](#)) that can be used to reduce subject attrition:

- Strengthening the client's study commitment by explaining the purpose and how the results will be used
- Paying subjects (or providing other incentives) for keeping appointments, completing interviews, and complying with other study requirements
- Collecting client locator information, including other people who will know the whereabouts of the client at the time of followup, and staying in contact with clients via phone calls or postcards

- Using information from official records and agencies to locate hard-to-find clients for followup interviews
- Using outreach workers who are familiar with the client's community to help locate clients for followup
- Including measures in the study design that make use of program or criminal justice records so that data will be available for all study clients regardless of attrition.

Outcomes Measures

A variety of measures have been used to assess the effectiveness and treatment outcomes for AOD-involved offenders. These outcome measures include changes in

- Drug use
- Criminal activity
- Personality traits
- Attitudes
- Vocational skills
- Employment
- Institutional adjustment
- Family relationships
- Involvement in social activities.

The specific measures selected should include behaviors specified in program goals and objectives. The treatment program designed to reduce substance use, decrease criminal involvement, improve self-concept, and increase job skills must include an evaluation designed to collect data on each of these variables.

The smaller the sample size, the lower the probability of detecting statistically significant treatment effects. This aspect of the research design, known as power analysis, is often overlooked, but it is important because program evaluations with sample sizes that are not large enough to detect treatment effects can waste resources and may lead to abandoning otherwise promising treatment approaches.

Outcomes measures can cover a wide variety of psychological and social behaviors, but the primary purpose of most treatment programs for offenders is to reduce drug use and the criminal activity associated with it. Regardless of the positive benefits programs may produce, criminal justice drug treatment programs that are unable to bring about significant reductions in drug use and recidivism cannot be regarded as effective. Thus, measures that focus on relapse and recidivism are commonly used as indicators of program effectiveness in criminal justice settings. Neither relapse nor recidivism are simple behavioral measures. Both can be used to refer to a variety of behaviors and can be defined in a variety of ways.

Relapse

Relapse is not clinically regarded as a treatment failure, but as an indication that the treatment plan should be changed to address the cause or circumstances associated with the relapse. Some

clinicians distinguish between the degrees of relapse -- from a single "slip," to sporadic use or a return to addiction. For research purposes, however, relapse often is defined as the single use of a specified drug during a given period of time. Various relapse studies have reported that more than 50 percent of people treated for alcohol or other drug dependence relapse within a year after a single treatment episode, and that that percentage increases with longer followup periods ([Maddux and Desmond, 1986](#)). As a result, treatment success can be measured as a reduction in the relapse rate when compared with the relapse rate of an untreated group or a group that received a different treatment.

Drug use can be measured either by urine tests or by self-report. Some studies rely on self-reported drug use only, while others ([Wish and Gropper, 1990](#)) use validated urine test results. Urine test results can be abstracted from client records at little cost for some treatment evaluations. For followup studies, clients can be asked to provide urine specimens following the interview and the cost of testing can be factored into the evaluation budget. The evaluator should carefully consider the drugs that are of greatest relevance to the objectives of the program being studied. A potential problem is that subjects may refuse to provide urine specimens. If specimens are not collected from a large number of clients, the study's purpose can be undermined. However, inadequate collection has not proven to be a major problem. For instance, in the Drug Use Forecasting program, 80 percent or more of those interviewed in jails agreed to provide a urine sample ([National Institute of Justice, 1992](#)).

Relapse is not clinically regarded as a treatment failure, but as an indication that the treatment plan should be changed to address the cause or circumstances associated with the relapse.

Although self-report results underestimate drug use ([Mieczkowski, 1990](#); [Rouse et al., 1985](#); [Wolber et al., 1990](#)), self-reports provide information about use patterns that cannot be obtained from drug testing. Thus, through self-reports, the evaluator can obtain reasonably reliable data on quantity and frequency of use, method of administration, circumstances of use, and reasons for use. These measures may be more useful for assessing the impact of a treatment program than merely determining whether the person tested positive at the 6-month followup interview.

Recidivism

[Waldo and Griswold \(1979\)](#) use the following definition of recidivism: "an offense committed by a person who has previously been convicted or adjudicated for an offense." This definition focuses on the behavior rather than "tendencies" or "proneness" and includes offenses that appear in official records and those that do not. In studies of treatment effectiveness, recidivism data usually are obtained from official criminal justice records. In addition, studies also may ask subjects about their criminal behavior during the followup period ([Weis, 1986](#)). But even if evaluators decide to rely on official records as the measure of recidivism, they must decide which level of contact with the criminal justice system will be used to determine recidivism. Should the measure of recidivism be rearrest, reconviction, reincarceration, or technical violations of probation or parole?

Although there may be theoretical or methodological reasons for selecting one measure or a combination of measures, in practice, the choice will depend on the purpose of the study, the access the evaluator has to official records, and budget constraints. In addition to recidivism, official records often permit the evaluator to select other measures of the program's impact on criminal behavior, such as the number of rearrests or technical violations during the followup period, the types and severity of the offense(s) committed, the time to rearrest from program discharge, the length of any sentence imposed, and the annual rate of arrest, controlling for time on the street.

The interpretation of recidivism rates is not always straightforward. Although most criminal justice outcome studies use recidivism from official records, researchers have noted ([Turner et al., 1992](#)) that "recidivism is actually a product of the offender's underlying criminality and the System's ability to detect that criminality and act on it (e.g., arrest probability)." For example, offenders in a community treatment program are committing fewer crimes than those not in treatment, but the increased supervision and surveillance associated with the treatment program increases the probability that their crimes and technical violations will be detected. Thus, even though the actual rate of the criminal behavior for the treatment group may be lower than for the comparison group, the treatment group's "official" behavior may be the same or worse than that of the comparison group. Collecting self-report data would be one way of clarifying the relationship between the offender's criminal behavior and the criminal justice system's ability to respond to the behavior.

If evaluators decide to rely on official records as the measure of recidivism, they must decide which level of contact with the criminal justice system will be used to determine recidivism. Should the measure of recidivism be rearrest, reconviction, reincarceration, or technical violations of probation or parole?

Endnote

1. This chapter was written by Michael L. Prendergast, Ph.D., Drug Abuse Research Center, University of California at Los Angeles.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

[Back Matter]

Appendix A -- Bibliography

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Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Appendix B -- CSAT Criminal Justice Treatment Planning Chart

The Criminal Justice Treatment Planning Chart is a 3 1/2 foot fold-out chart suitable for display. The reverse side of the chart contains a glossary of the terms used in the chart. There was no effective way to present this chart in electronic format.

A copy of the entire TIP containing the chart can be ordered from the National Clearinghouse of Drug and Alcohol Information (NCADI). The order number for TIP 17: Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System is BKD165. It is free and can be ordered from NCADI's electronic catalog at <http://ncadi.samhsa.gov/> or by calling 1-800-729-6686.

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Appendix C -- Sample Interagency Agreement

SOUTH DAKOTA DEPARTMENT OF CORRECTIONS INTERAGENCY AGREEMENT:

PARTICIPANTS:

1. Unified Judicial Systems (UJS)
2. S.D. Division of Alcohol and Drug Abuse (DIV)
3. S.D. Department of Corrections Substance Abuse Program (DOC)

PURPOSE:

To provide for early identification of chemically dependent offenders to be treated in the community and to ensure that drug-involved offenders receive the appropriate treatment and supervision through early intervention, incarceration, treatment, and aftercare services.

IDENTIFIED CLIENTS:

Adolescent and adult drug/alcohol-involved offenders.

INTERAGENCY GOALS:

1. The UJS, DIV, and DOC will cooperate in the establishment of an alcohol/drug screening process to determine which offenders should be referred to a core service agency for alcohol/drug assessment. The results of the assessment will be included in the development of a recommendation to the court.
2. Those individuals not institutionalized in a State corrections facility will receive appropriate chemical dependency services at an accredited alcohol/drug program.
3. The DOC substance abuse program will assess all incoming individuals and, based on results of this assessment, will provide appropriate chemical dependency services.
4. The DOC substance abuse program will refer all adults who have completed treatment to an accredited community-based treatment program for aftercare

services. The DOC juvenile programs will make aftercare recommendations to the court services officers and will refer clients to community-based programs.

1. The three agencies will develop followup procedures. The followup forms developed by the Attorney General's task force on drugs and that are currently in use will be utilized.
2. The three agency directors will meet quarterly to discuss the agreement process. Meetings will also be held as needed, and other individuals may attend from time to time.
3. The three agencies will abide by 42 C.F.R., Part 2. The division will provide training in the area of confidentiality issues to UJS and DOC staff.
4. The policies of the three agencies regarding the use of urinalysis testing and breathalyzer use will be followed. Information will be shared regarding testing results when releases of information are obtained from clients.
5. When alcohol/other drug offenders are referred to community-based agencies, the financial eligibility requirements of the agencies will apply. The DOC substance abuse programs will be provided at no cost to the clients.
6. At the quarterly meetings, the three agency directors will discuss upcoming training opportunities and the need for cross-training on various topics. Mailing lists for training events will be expanded to include representatives from all three agencies.
7. The natural supervision and chain-of-command processes will be followed by each agency.
8. This agreement will be reviewed on an annual basis. If problems develop, they will be discussed by the directors at the quarterly meetings.

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

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Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

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Rhode Island Medical Center

Cranston, Rhode Island

The Honorable Dalton A. Roberson, Sr.

Chief Judge

Detroit Recorder's Court

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Virginia S. Ryan, Ph.D.

Principal Investigator

Self Help Addiction Rehabilitation

Detroit, Michigan

The Honorable Linda Stout Saunders, J.D.

Acting Justice

Concord District Court Hearings Officer

New Hampshire Division of Mental Health and Developmental Services

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South King County Drug and Alcohol Recovery Centers

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Administrator, King County North Rehabilitation Facility

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Patricia L. Watson, M.Ed.

President

Corrections Alternatives and Concepts

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Supervisor II, Correctional Program Specialist

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Chief Probation Officer, Court of Common Pleas

Cuyahoga County Juvenile Court

Cleveland, Ohio

Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series 17

Exhibits

Exhibit 4-1 Forms of Intermediate Sanctions

- **Means-based fines (also called "day" fines).** The total amount of these fines is calibrated to both the severity of the crime and the discretionary income of the offender, with the calibration and calculation established by the court as a whole for all cases in which this type of fine is to be imposed. (This type of fine contrasts with traditional fines that are imposed at the discretion of the judge according to ranges set by the legislature for particular offenses.) Defendants with more income (and/or fewer familial obligations) pay a higher overall fine than those with lower incomes (and/or more obligations) for the same crime. This approach to setting the fine amount is typically coupled with expanded payment options and collection procedures that are tighter than usual.
- **Community service.** This is the performance by offenders of services or manual labor for government, private, or nonprofit organizations for a set number of hours with no payment. Community service can be arranged for individuals, case by case, or organized by corrections agencies as programs. For example, a group of offenders can serve as a work crew to clean highways or paint buildings.
- **Restitution.** Restitution is the payment by the offender of the costs of the victim's losses or injuries and/or damages to the victim. In some cases, payment is made to a general victim compensation fund; in others, especially where there is no identifiable victim, payment is made to the community as a whole (with the payment going to the municipal or State treasury).
- **Special needs probation programs or caseloads.** In these approaches to intermediate sanctions, officers with special training carry a restricted caseload. Typically, these approaches are used with offenders who have committed some categories of domestic violence, sex offenses, and driving under the influence, and with mentally ill, developmentally disabled, or substance-abusing offenders. Supervision in a specialized caseload may mean more intensive or more intrusive supervision than in routine caseloads, the provision of enhanced social and psychological services, and/or specific training or group activities, such as anger management classes or victim impact meetings.
- **Outpatient or residential AOD abuse treatment centers.** Both public and private treatment

centers may be contracted to provide treatment to offenders, as described in this TIP.

- **Day centers or residential centers for other types of treatment or training.** These centers are established to provide services other than AOD abuse treatment. For example, a center may provide skills training to enhance offenders' employability.
- **Intensive supervision probation.** The level and types of supervision that are labeled intensive vary widely but usually involve closer supervision and greater reporting requirements than regular probation for offenders. This level can range from more than five contacts a week to fewer than four per month. Supervision usually entails other obligations (to attend school, have a job, participate in treatment, or the like). *Intensive supervision parole* has similar requirements and variations but is usually provided by parole agents to offenders who have completed a prison term and who are serving the balance of their sentences in the community.
- **Day reporting centers.** Under the terms of this intermediate sanction, offenders must report to the center for a certain number of hours each day, and/or report by phone throughout the day from a job or treatment site, as a means of monitoring and incapacitating them.
- **Curfews or house arrest (with or without electronic monitoring).** Offenders are restricted to their homes for various durations of time, ranging from all the time to all times except for work or treatment hours, with a few hours for recreation. Frequently, the curfew or house arrest is enforced by means of an electronic device worn by the offender which can alert corrections officials to his or her unauthorized absence from the house.
- **Halfway houses or work release centers.** Offenders are restricted to the facility but can leave for work, school, or treatment. The facility is in the community or attached to a jail or similar institution.
- **Boot camps.** Typically, a sentence to a boot camp (also called shock incarceration) is for a relatively short time (3 to 6 months). As the name implies, boot camps are characterized by intense regimentation, physical conditioning, manual labor, drill and ceremony, and military-style obedience. (Because boot camps are a form of incarceration, some in the criminal justice field reject their inclusion in the category of intermediate sanctions. Others include boot camps because placement in them is intended to take the place of a longer, traditional prison term.)

Exhibit 5-1 Center for Substance Abuse Treatment Model for Comprehensive Alcohol and Other Drug (AOD) Abuse Treatment

A model treatment program includes

- **Assessment,** including a medical examination, drug use history, psychosocial evaluation, and where warranted a psychiatric evaluation, as well as a review of socioeconomic factors and eligibility for public health, welfare, employment, and educational assistance programs.
- **Same-day intake** to retain the patient's involvement and interest in treatment.
- **Documentation of findings and treatment** to enhance clinical case supervision.
- **Preventive and primary medical care** provided onsite.
- **Testing for infectious diseases** at intake and at intervals throughout treatment, for infectious diseases such as hepatitis, retrovirus, tuberculosis, HIV/AIDS, syphilis, gonorrhea, and other sexually transmitted diseases.
- **Weekly random drug testing** to ensure abstinence and compliance with treatment.
- **Pharmacotherapeutic interventions** by qualified medical practitioners, as appropriate for

those patients having mental health disorders, those addicted to opiates, and HIV-seropositive individuals.

- **Group counseling interventions** to address the unique emotional, physical, and social problems of HIV/AIDS patients.
- **Basic substance abuse counseling**, including psychological counseling, psychiatric counseling, and family or collateral counseling provided by persons certified by State authorities to provide such services. Staff training and education are integral to a successful treatment program.
- **Practical life skills counseling**, including vocational and educational counseling and training, frequently available through linkages with specialized programs.
- **General health education**, including nutrition, sex and family planning, and HIV/AIDS counseling, with an emphasis on contraception counseling for adolescents and women.
- **Peer/support groups**, particularly for those who are HIV-positive or who have been victims of rape or sexual abuse.
- **Liaison services** with immigration, legal aid, and criminal justice system authorities.
- **Social and athletic activities** to retrain patients' perceptions of social interaction.
- **Alternative housing** for homeless patients or for those whose living situations are conducive to maintaining the addicted life-style.
- **Relapse prevention**, which combines aftercare and support programs such as the self-help groups Alcoholics Anonymous and Narcotics Anonymous, within an individualized plan to identify, stabilize, and control the stressors that trigger and promote relapse to substance abuse.
- **Outcome evaluation** to enable refinement and improvement of service delivery.

Exhibit 8-1 Consent for the Release of Confidential Information: Criminal Justice System Referral

I, _____, hereby consent to

(Name of defendant)

communication between _____ and

(Treatment program)

(Court, probation, parole, and/or other referring agency)

the following information: _____

(Nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with

the treatment program, prognosis, and

I understand that this consent will remain in effect and cannot be revoked by me until:

_____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

(other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may redisclose it only in connection with their official duties.

(Date)

(Signature of defendant/patient)

(Signature of parent, guardian, or authorized representative, if required)

Exhibit 8-2 Consent for the Release of Confidential Information

I, _____, authorize

(Name of patient)

(Name or general designation of program making disclosure)

to disclose to _____

(Name of person or organization to which disclosure is to be made)

the following information: _____

(Nature of the information, as limited as possible)

The purpose of the disclosure authorized herein is to: _____

(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

(Date)

(Signature of participant)

(Signature of parent, guardian, or
authorized representative, if required)

Exhibit 8-3 Prohibition on Rediscovering Information Concerning AOD Abuse Treatment Patients

This notice
accompanies
a disclosure
of
information

concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general

authorization
for the
release of
medical or
other
information is
NOT sufficient
for this
purpose. The
Federal rules
restrict any
use of the
information
to criminally
investigate or
prosecute any
alcohol or
drug abuse
patient.

Exhibit 8-4 Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____

(Name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide the following services:

(Nature of services to be provided)

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the

Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and

2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the Federal confidentiality regulations, 42 C.F.R. Part 2.

Executed this ____ day of _____, 199__.

President
XYZ Service Center
(Address)

Program Director
(Name of Program)
(Address)

Exhibits

Exhibit 5-1 Center for Substance Abuse Treatment Model for Comprehensive Alcohol and Other Drug (AOD) Abuse Treatment

A model treatment program includes

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- **Weekly random drug testing** to ensure abstinence and compliance with treatment.
- **Pharmacotherapeutic interventions** by qualified medical practitioners, as appropriate for those patients having mental health disorders, those addicted to opiates, and HIV-seropositive individuals.
- **Group counseling interventions** to address the unique emotional, physical, and social problems of HIV/AIDS patients.
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- **Practical life skills counseling**, including vocational and educational counseling and training, frequently available through linkages with specialized programs.
- **General health education**, including nutrition, sex and family planning, and HIV/AIDS counseling, with an emphasis on contraception counseling for adolescents and women.
- **Peer/support groups**, particularly for those who are HIV-positive or who have been victims of rape or sexual abuse.
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- **Social and athletic activities** to retrain patients' perceptions of social interaction.
- **Alternative housing** for homeless patients or for those whose living situations are conducive to maintaining the addicted life-style.
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- **Outcome evaluation** to enable refinement and improvement of service delivery.

